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INTERIM STUDY
BY THE
SELECT COMMITTEE ON MEDICAL MALPRACTICE

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Medical Malpractice

December 1976

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MEDICAL MALPRACTICE

A REPORT TO THE

FORTY-FIFTH LEGISLATURE

Select Committee on Medical Malpractice

December 1976

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SUMMARY OF FINDINGS AND RECOMMENDATIONS

The Select Committee on Medical Malpractice finds that there is a medical malpractice insurance problem in Montana; that the problem appears to be increasing; and that the problem is related to the problems emerging in other professional, industrial and products liability insurance lines.

The Select Committee on Medical Malpractice recommends that the Forty-Fifth Montana Legislature establish a Select Committee to specialize in medical malpractice insurance and related liability problems.

INTRODUCTION AND BACKGROUND

Early in 1976 legislative leaders recognized that the problems alleged to exist in relation to medical malpractice insurance were significant and complex issues that demanded resolute study and analysis. In an effort to understand the dimensions of the problem in Montana, the Legislative Council and the Joint Committee on Rules of the Montana Legislature authorized an interim study on March 25, 1976. An eight member Select Committee on Medical Malpractice was created with members appointed with equal balance politically by the Speaker of the House of Representatives and by the Senate Committee on Committees. This Select Committee was authorized to hold not more than three meetings after June 1, 1976 to solicit and receive public testimony, to conduct research and to report appropriate recommendations, findings and conclusions to the Forty-Fifth Montana Legislature.

The study undertaken by the Select Committee was fortunate to be able to benefit from the research work and analysis of the numerous other states that have considered this question in detail. The Select Committee was further fortunate to be able to perform its fact-finding work in a deliberate and rational manner avoiding the "crisis" atmosphere that has accompanied legislative investigation in many other states attempting to deal with this serious question.

The Select Committee conducted its study by holding a series of three public hearings in July, August, and October of 1976, and received both written and oral testimony from a wide variety of sources, including representatives of numerous professions, organizations and interested persons immediately involved with medical malpractice considerations.

A wide spectrum of views were presented at these hearings and considerable information on various issues was collected by the Select Committee. Several pieces of model legislation were presented by interested organizations, most notably 16 draft bills were prepared and presented for the Select Committee's consideration by the Montana Medical Association.

Testimony heard by the Select Committee revealed little, if any, agreement among health care providers, lawyers, insurance industry representatives and consumers appearing before the committee about the extent of, causes for, or reasonable legislative responses to the medical malpractice problem in Montana.

Recognizing the lack of consensus among the various interests and the severe limitations of data available, the Select Committee concentrated on those basic issues raised by the medical malpractice problem and a review of a wide variety of "solutions" that were proposed in the literature, enacted by other states, or offered by testifiers as remedies for the problem in Montana.

The Select Committee was presented with many descriptions of the problem and myriad solutions from several quarters. The Select Committee concluded, despite the meager reliable data available, that there is a problem with medical malpractice in Montana and it is increasing. The shape, scope and total dimensions of the problem are not clear. The Select Committee concluded that the complexities of the medical malpractice and the various proposals for dealing with it are such that there should be a Select Committee during the Forty-Fifth Montana Legislature to specialize in medical malpractice and related liability problems. Such a Select Committee should logically use the expertise and knowledge built up over the course of this interim study.

This report was prepared at the direction of the Select Committee on Medical Malpractice by the staff of the Research and Reference Services Division, Montana Legislative Council to be distributed to the members of the Forty-Fifth Montana Legislature. This report contains a summary of the research on the medical malpractice problem in the United States and Montana, the facts that the Select Committee gathered and a brief description of the various recommendations to alleviate the problem.

This report is intended as a useful guide and ready reference tool to busy legislators. All supporting documents, research and comprehensive minutes of the Select Committee's hearings are on file with the Legislative Council and are readily available to any legislator in the reference library. The material in this report is primarily the product of the staff research effort and should not be construed as reporting the official findings or recommendations of the Select Committee on Medical Malpractice. Much of the information in this report is based on the findings of study commissions in various other states. "The Malpractice Issue in Washington" developed by the Health Policy Analysis Program, Department of Health Services, University of Washington, November, 1975, is a valuable resource and was used extensively in preparing this report.

THE MEDICAL MALPRACTICE "CRISIS" NATIONALLY

The incidence of medical malpractice claims filed each year in the United States is rising at a significant rate. Insurance industry reports place this increase at approximately 10 percent each year. The concern over this phenomenon by physicians, insurance companies, lawyers, and health care consumers led to several major studies of the problem by the federal government beginning before 1969. Recently, much more has been said and written concerning what many have characterized as the "medical malpractice crisis." This crisis, whether real or imaginary, has demanded the attention of state legislatures across the nation and has been categorized as the single most common legislative problem facing the states in the last two years. Virtually every state in the nation has considered the situation and most have enacted some sort of remedial legislation.

The medical malpractice problem nationally has been precipitated by the emergence of a major symptom of the problem -- the unavailability of professional medical liability insurance coverage at what are perceived to be reasonable rates.

Many insurance companies, as a result of increased claims and higher awards or settlements, have dropped the medical malpractice line. Others, who have remained in the market, have been forced to resort to higher premiums.

But the medical malpractice problem is not merely a question of rapidly escalating premium rates and decreased availability of insurance. Examination of the existing medical malpractice claim resolution system reveals that it is inefficient -- because of the low return of the premium dollar to the injured person (less than half the premium dollar reaches the injured person) -- and inequitable -- because many injured patients who deserve compensation but do not receive it.

Medical malpractice insurance premiums in the United States account for approximately two percent of all expenditures for health care. Whether this is an acceptable cost that society is willing to bear has been a major issue in every medical malpractice debate.

The rising cost of medical malpractice insurance threatens to distort the delivery of health services. The practice of "defensive medicine" -- the reluctance to take on unusually difficult cases, or employing more diagnostic and therapeutic procedures than a case calls for, to bar any potential claims of negligence -- is widespread and may be adding to the cost of health care and contributing to the deterioration of traditional physician-patient relationships. Whether "defensive medicine" really adds unreasonably to the costs of care has not been demonstrated. Some commentators even believe that "defensive

medicine" is often better quality medicine and beneficial to patients.

The numerous adverse effects of the medical malpractice problem have been identified for consumers, health care providers, health and welfare plans and the insurance industry. The high cost of medical malpractice insurance is passed on by health care providers to the health care consumer, and to health benefit plan participants. The increased cost is also passed on to the taxpayer through Medicare and Medicaid. The cummulative affect of the medical malpractice is to add to the already high cost of health care services. In the final analysis, it is the consumer -- the citizen who must pay the cost of medical injuries and of the existing medical loss allocation system.

The price the broader public will ultimately have to pay for the problems associated with medical malpractice includes both higher medical care and health insurance costs as well as more limited access to health care as health care providers are discouraged in branches of medicine and from delivering certain high risk services.

The medical malpractice "crisis" is probably only the tip of a liability insurance "crisis". Nationally, trends indicate similar problems are emerging in other professional and industrial liability areas and in products liability. There are also major cost problems with auto liability and public official/public entity liability. States, cities, counties, and school districts are beginning to experience problems with availability and cost of liability insurance.

CHART I

PERCENT INCREASE NATIONWIDE IN MEDICAL
MALPRACTICE CLAIMS BETWEEN 1970 AND 1975

State	Percentage Increase in Claims	State	Percentage Increase in Claims
Alabama	25%	Montana	50%
Alaska	50	Nebraska	ND
Arizona	ND	Nevada	ND
Arkansas	71	New Hampshire	ND
California	40	New Jersey	50
Colorado	ND	New Mexico	337
Connecticut	195	New York	273
Delaware	75	No. Carolina	250
Florida	157	No. Dakota	ND
Georgia	50-60	Ohio	ND
Hawaii	ND	Oklahoma	65
Idaho	300	Oregon	100
Illinois	ND	Pennsylvania	ND
Indiana	ND	Rhode Island	366
Iowa	ND	So. Carolina	ND
Kansas	ND	So. Dakota	ND
Kentucky	35	Tennessee	110
Louisiana	100	Texas	ND
Maine	25	Utah	300
Maryland	159	Vermont	25
Massachusetts	50	Virginia	71
Michigan	100	Washington	30
Minnesota	152	West Virginia	30
Mississippi	ND	Wisconsin	ND
Missouri	ND	Wyoming	300

ND - No data
Source: American Medical Association

CHART II

STATE BY STATE COMPARISON OF EXISTING INSURANCE SERVICES OFFICE
RATES FOR PHYSICIANS AND SURGEONS MALPRACTICE COVERAGE
AS OF OCTOBER 1, 1975*

State	Rates			
	Class 1		Class 5	
	25/75	100/300	27/75	100/300
Alabama	115	200	703	1,244
Arizona	2,128	3,703	17,039	30,159
Arkansas	260	452	2,080	3,682
California	3,491	6,074	27,919	49,417
Colorado	--	--	--	--
Connecticut	517	900	4,137	7,322
Delaware	291	434	2,331	3,543
District of Columbia	468	697	3,744	5,691
Florida**	2,043	3,555	16,339	28,920
Georgia	332	578	2,652	4,695
Idaho	786	1,368	6,296	11,144
Illinois	--	--	--	--
Indiana	468	814	3,743	6,625
Iowa	483	720	3,863	5,872
Kansas	238	355	1,905	2,896
Kentucky	387	673	3,095	5,478
Louisiana	482	718	3,856	5,861
Maine	336	501	2,686	4,083
Maryland	131	168	804	1,061
Massachusetts	337	502	2,699	4,102
Michigan	2,464	4,287	19,708	34,883
Minnesota	634	1,277	5,873	10,395
Mississippi	283	492	2,268	4,014
Missouri	822	1,430	6,574	11,636
Montana	1,125	1,958	9,012	15,951
Nebraska	730	1,270	5,838	10,333
Nevada	732	1,091	5,859	8,906
New Hampshire	78	116	389	591
New Jersey	564	722	4,515	5,960
New Mexico	440	766	3,518	6,227
New York**	1,183	1,763	14,200	21,584
North Carolina	95	122	476	628
North Dakota	150	261	1,197	2,119
Ohio	619	1,077	4,955	8,770
Oklahoma	374	557	2,995	4,552
Oregon	305	531	2,438	4,315
Pennsylvania**	516	769	3,182	4,837
Rhode Island	191	244	957	1,263
South Carolina	145	252	1,161	2,055
South Dakota	529	920	4,229	7,485

CHART II (cont.)

State	Rates Class 1 25/75	Class 1 100/300	Class 2 27/75	Class 2 100/300
Tennessee	925	1,378	7,409	11,262
Texas	--	--	--	--
Utah	686	1,194	5,479	9,698
Vermont	277	413	2,213	3,364
Virginia	509	886	4,069	7,202
Washington	341	593	2,727	4,827
West Virginia	365	544	2,921	4,440
Wisconsin	719	1,251	5,751	10,179
Wyoming	518	901	4,147	7,340
Hawaii	486	724	3,889	5,911
Alaska	295	513	2,357	4,172
Puerto Rico	161	280	990	1,752
MONTANA'S National Raning	6th	5th	6th	6th

*Source: Insurance Services Office

**This jurisdiction has numerous rating territories. Consequently, only the rates for the highest territory are listed.

CAUSES OF THE MEDICAL MALPRACTICE INSURANCE PROBLEM

A review of the literature on medical malpractice insurance reveals there is little agreement among health care providers, consumers, lawyers and insurance companies as to the causes of the current medical malpractice situation. Mere surface consideration of the alleged problem could easily lead to the conclusion that combination of an increasing frequency of medical malpractice claims and the increase in the average size of court awards and settlements of these claims are the causes of rising medical malpractice insurance rates. However, comprehensive analysis by numerous researchers has supported the premise that more frequent claims and increasing average size of awards are, like rising insurance rates, simply symptoms of the problem.

No reliable data exists to identify the agreed upon causes of the current medical malpractice problem. However, the one thing that all involved, informed interests agree upon is that the issue is extremely complex involving an intricate interplay of the medical, legal and insurance professions and general social attitudes. There are significant differences in emphasis concerning the most important causes of the medical malpractice problem from each of the interest group perspectives. Because there are no conclusive objective data identifying one simple cause or even the leading cause, this report will not attempt to order the significant causes by importance or impact.

Most frequently cited as the underlying causes for the problem with medical malpractice insurance are:

1. *The increasingly impersonal nature of the health care provider -- consumer (especially the physician-patient) relationship.*

Increased specialization and complaints against medical science apparently have resulted in an adverse affect on the physician-patient relationship. The disappearance of the house call, frequent unavailability of physicians, long waits for appointments, assembly-line case handling and lack of personal contact with specialists or surgeons have added to the decline. In addition, public resentment of the high cost of medical care is also frequently cited as a contributor to the medical malpractice problem. Medical costs, however, like medical malpractice insurance premiums, have greatly increased over the last few years for many reasons that are unrelated to the behavior of individual health care providers.

2. *Rising consumer expectations.*

Publicity on the many advances in medical science coupled with the so-called "Marcus Welby syndrome" -- the myth of the infallible, all-knowing, all-powerful physician -- have elevated public expectations of the medical profession. Television

medical programs (Marcus Welby, Doc, The Practice, Dr. Kildare, Medical Center) and, to a certain degree, the medical profession itself have contributed to heightened consumer expectations of medical science. With these inflated expectations the consumer is more easily disappointed when confronted by day to day medicine.

3. Increased publicity on medical malpractice.

The increase in general publicity surrounding the medical malpractice issue and the large requests, awards or settlements for injury, not to mention the news coverage given to physician strikes in California, has raised the level of public awareness of medical malpractices. This publicity is said to make the consumer public aware of their legal rights and remedies, and prompts some to fully investigate the desirability of litigation when they have suffered an untoward medical injury. This awareness may be one of the causes of increased claims.

4. Advances in technology.

Advances in medical technology have overall had a positive impact on medical care. However, at the same time, medical technology has become more complex and has increased the chance for error. The potential for mistakes or bad results has and continues to increase with the increases in the scope of services and the expanding medical technology thereby adding to the risks associated with medical practice.

5. The so-called "legal rights explosion".

Many argue that our society is simply more litigious than ever before. This propensity to sue is said to be more prevalent in the United States than in most other nations. Even if medical negligence or malpractice may not be increasing, people are now more aware of their rights and more willing and able to seek reparation through the judicial system.

6. Increased sophistication of legal counsel.

The general increase in expert malpractice lawyers with substantial knowledge of the complexities of medical practice results in more successful claims. It is alleged that trial lawyers are becoming more proficient in recognizing and litigating medical malpractice claims.

7. Insurance industry stock market losses.

A number of medical malpractice insurers experienced heavy stock market losses in the early 1970's which cut their anticipated reserves and resulted in the significant surge to raise rates or to pull out of the medical malpractice insurance market altogether. The entire insurance industry, as well as most other

investors, experienced stock market losses while at the same time double digit inflation increased industry costs. The size of settlements and awards was partly reflective of inflation.

8. Inadequate insurance underwriting.

Most medical malpractice insurance carriers have not specialized in this line, but carry malpractice insurance as a sideline. Consequently, underwriting for medical malpractice has seldom been specialized and is not well developed. Inadequate underwriting practices that failed to recognize the rapidly changing claim environment are cited as a major cause of the "crisis" atmosphere around medical malpractice insurance. Premiums should have been increasing steadily over the past decade, but they were not. The combined pressures of inflation and investment losses only exaggerated the effects of inadequate underwriting practices.

9. Expanded use of the judicial system as an alternative for health care provider accountability.

It appears to be contradictory that allegations of medical malpractice, successful plaintiffs' suits, and large judgments against health care providers have arisen during a period of time when more physicians and other health care providers than ever before hold credentials attesting to their medical excellence and when public spending for the purchase of medical services is at its highest level in history. Medical malpractice claims are seen by some as an indicator of consumer dissatisfaction with medical care and as an alternative to professional assurances of accountability and quality control. With a poor track record of disciplining and maintaining quality service on the part of the individual members in the profession, it is said that the public has tended to bypass traditional professional disciplinary procedures and uses the courts to achieve professional accountability. With this phenomenon has come continued demands upon professions to assume greater responsibility for discipline and quality of care.

10. The widened structure of the legal framework.

Conceptual expansion, primarily by the judiciary, of certain legal doctrines has widened the scope of medical malpractice liability in many jurisdictions, thereby increasing the grounds for successful claims by health care consumers. Particularly, the application of the doctrine of res ipsa loquitur, the expansion of the "locality rule", and the interpretation of informed consent are frequently listed as contributing to the medical malpractice insurance problem.

THE MONTANA MEDICAL MALPRACTICE EXPERIENCE

Throughout the ccurse of the study and fact-finding investigations, the need for adequate, timely and reliable information was identified as a major barrier to determining the extent of the medical malpractice problem in Montana, the national implications and trends or the efficacy of proposed solutions.

The major problem was finding enough information to determine whether Montana had a medical malpractice problem, and if so, what kind of a problem it was, how severe, and who is affected most.

There is now no place, either in a governmental agency or any private insurance carrier where meaningful statistics that are specific, reliable, and credible are accumulated. Without this kind of information, it seems impossible to develop innovative remedial legislation or prevention programs which can potentially contribute to a reduction in the overall costs associated with the medical malpractice insurance system in Montana.

It has proven to be next to impossible to gather any concrete information on the medical malpractice experience in Montana from either the insurance industry or the legal and medical professions. Neither the medical, the legal, nor the insurance industry seems able to supply such elementary data as the number of medical malpractice claims filed in Montana, the reasons for the claims and the ultimate disposition of the claims.

Information supplied by the insurance industry concerning its Montana experience is, more often than not, so sketchy that it is difficult to understand what it is that the insurance carriers are attempting to prove or disprove. Data from industry income or investments were not obtainable. Since the profitability or lack of profitability of insurance operations is highly dependent on returns on the company's investments of premium income (and especially the reserves against open files) determining the true financial status of the insurance companies, and whether rate increases are justified, is rather difficult without information concerning investments.

Recognizing the inherent limitations of available data, some generalizations about the current situation in Montana can be made. Although conclusive data for predicting future trends is scarce, at present in Montana, the medical malpractice situation appears to be less critical than in many other states. The availability of medical malpractice insurance to health care providers in Montana has not yet reached crisis proportions. Premium costs continue to increase, but coverage is generally available at what would seem to be still affordable prices. Although not yet a serious problem, continued availability of insurance coverage is of pressing concern, especially to the organized medical community in Montana.

CHART III

INSURANCE COMPANIES PROVIDING MEDICAL LIABILITY COVERAGE IN MONTANA, JANUARY - DECEMBER, 1975

		Premiums Written	Premiums Earned	Paid Losses	Incurred Losses	Paid Losses : By Premiums Earned
1.	Aetna					
	Standard Fire Insurance (subsidiary)	$1,168,272	$1,165,694	$ 21,412	$120,203	2%
	Casualty & Surety	172,456	168,824	142,801	225,160	84%
2.	St. Paul Fire & Marine	652,489	360,628	-0-	78,500	0%
3.	Truck Insurance Exchange	225,834	212,038	13,671	144,173	6%
4.	Glacier General Assurance	178,543	90,228	339	551,790	0%
5.	Guaranty National Insurance	69,563	59,655	-0-	2,500	0%
6.	Allied Insurance	57,328	31,203	100% Reinsured w/Insurance Co. of North America		
7.	Hartford Accident & Indemnity	23,177	15,640	-0-	100	0%
8.	Western Casualty & Insurance	16,519	13,040	-0-	1,000	8%
9.	Fidelity & Casualty of New York	15,750	13,560	61	21,061	0%
10.	Pacific Indemnity	12,374	8,627	-0-	-0-	0%
11.	Globe Indemnity	11,811	11,018	-0-	-0-	0%
12.	General Insurance	9,982	3,507	-0-	-0-	0%
13.	St. Paul Mercury INsurance	9,458	6,008	-0-	-0-	0%
14.	Midland Insurance	6,975	-0-	-0-	-0-	0%
15.	Pacific Insurance	6,683	5,754	-0-	-0-	0%
16.	Insurance Co. of North America	4,993	18,889	675	8,175	4% *
17.	Continental Insurance	2,988	2,573	1,198	698	47%
18.	Chicago Insurance	2,806	880	-0-	-0-	0%
19.	Pacific Employees Ins.	2,674	2,514	32	32	0%
20.	Empire Fire & Marine	1,527	1,480	-0-	-0-	0%
21.	Capitol Indemnity Corporation	975	428	-0-	-0-	0%
22.	Vigilant Insurance	857	538	-0-	-0-	0%
23.	United Pacific Insurance	696	623	-0-	-0-	0%
24.	Jefferson Ins. of New York	526	241	-0-	-0-	0%
25.	Northwestern National Casualty	500	178	-0-	-0-	0%
26.	Northwest National Ins.	281	109	-0-	-0-	0%
27.	Argonaut Northwest Ins.	248	248	-0-	(150)	0%
28.	Commercial Union Ins.	156	160	-0-	-0-	0%
29.	Travellers Indemnity Co.	149	29	-0-	21	0%
30.	Glens Falls Ins. Co.	129	111	-0-	-0-	0%
31.	United States Fidelity & Guaranty	(593)	34,855	113,566	29,123	326%
32.	Western Fire Ins.	(2,402)	2,496	-0-	-0-	0%
33.	Liberty Mutual Ins.	(4,443)	8,538	40,000	(29,147)	468%
34.	Argonaut Insurance	(23,586)	9,976	1,825	162,825	18%

* Reinsured Allied Insurance policies.

Source: Compiled by Insurance Division, Auditor's Office.

Aetna Life and Casualty, through their group policy with the Montana Medical Association (MMA) currently underwrites medical malpractice coverage for approximately 75-80 percent of Montana physicians and surgeons. Aetna has agreed to continue the Montana Medical Association group program until at least January 1, 1978. However, Aetna makes no guarantee of rates in this agreement. In 1976, Aetna requested and received an average 76 percent increase for its complete coverage package. Aetna's five-year agreement with the Montana Medical Association is not a binding legal contract but is expressed in a letter of intent. Aetna has given no indication of pulling out of the Montana medical malpractice insurance market, but the five-year agreement must be renegotiated before 1978.

The likelihood of an availability crisis is unclear. The increase in the total cost is at the center of the medical malpractice issue and could cause problems in the future. This potential for a problem warrants consideration. The issue of availability of medical malpractice insurance at a cost that is perceived to be reasonable by physicians will remain a potential problem unless something can be done to control the basic underlying irritant -- the trend of increasing costs.

The most visible evidence of increasing costs associated with the medical malpractice system is the increasing cost of premiums. Insurers cite two major types of data to support and justify premium increases. The severity (the increasing cost per claim) and frequency (increasing number of claims) appear to be increasing; however, accurate measurements of the increase are hampered by lack of data and the ambiguities of reserving practices. More information appears to be needed on reserving policies and how these policies affect medical malpractice insurance rate calculations. The data presented in this report have serious limitations and reveal important gaps that need to be filled.

Testimony from the Montana Medical Association pointed out that more and more Montana physicians are practicing without the benefit of medical malpractice insurance. A recent MMA survey indicates that approximately 20 percent of Montana's physicians and surgeons are "going bare" -- practicing without professional liability coverage.

CHART IV
AETNA LIFE AND CASUALTY
MMA PACKAGE PREMIUM COMPARISON

	Effective Date						
	1/1/73	1/1/74	% Change from previous year	1/1/75	% Change from previous year	1/1/76	% Change 1/1/75 to 1/1/76
Class I - Physicians - no surgery	536	538	+0	918	+70.6	1560	+69.9
Class II - Physicians - minor surgery or assist in major surgery on own patients	883	886	+0	1598	+80.4	2746	+71.8
Class III - Surgeons - general practitioners who perform major surgery or assist in major surgery on other than their own patients.	1981	1897	-4.2	2865	+51	5038	+75.9
- Opthalmologists							
- Proctologists							
Surgeons - Specialty							
Anesthesiologists	3247	3108	-4.3	4720	+51.9	8338	+76.7
Cardiac Surgeons	2614	2503	-4.2	4720	+88.6	8338	+76.7
Neurosurgeons	3247	3108	-4.3	7504	+141.4	13,287	+77.1
Obstetricians - Gynecologists	3247	3108	-4.3	5649	+81.8	9987	+76.8
Orthopedists	3247	3108	-4.3	7504	+141.4	13,287	+77.1
Otolaryngologists - plastic surgery	3247	3108	-4.3	4720	+51.9	8338	+76.7
Otolaryngologists - no plastic surgery	2614	2503	-4.2	4720	+88.6	8338	+76.7
Plastic Surgeons	3247	3108	-4.3	5649	+81.6	9987	+76.8
Surgeons - General	2614	2503	-4.2	4720	+88.6	8338	+76.7
Thoracic Surgeons	2614	2503	-4.2	7504	+200	13,287	+77.1
Urologists	2614	2503	-4.2	3792	+51.5	6688	+76.4
Vascular Surgeons	2614	2503	-4.2	7504	+200	13,287	+77.1

*Source: Aetna Life & Casualty Report to the Montana Medical Association, October 1975.

MEDICAL MALPRACTICE

DATA: JULY 1, 1975 TO FEBRUARY 1, 1976

	Total Claims	Claims in Which Indemnity Paid	Claims in Which $10,000 or More Indemnity Paid	Indemnity Paid	Number of Physicians	No. of Injuries Per 100 Physicians	Indemnity Per Physician
Alaska	5	2	1	38226	399	1.25	96
Alabama	250	33	9	298579	3457	7.23	86
Arkansas	45	17	8	784497	1973	2.28	398
Arizona	154	50	25	3090573	3380	4.56	911
California	2447	1103	485	37329127	42333	5.78	882
Colorado	131	44	15	476521	4583	2.86	104
Connecticut	145	84	27	1289952	6244	2.32	207
District of Columbia	192	81	37	3894481	3980	4.82	979
Delaware	62	13	6	317488	813	7.63	391
Florida	536	200	83	6857532	11828	4.36	580
Georgia	117	24	8	517510	6000	1.95	86
Hawaii	41	6	2	53100	1317	3.11	40
Iowa	75	46	17	1047837	2995	2.50	350
Idaho	32	17	3	89181	762	4.20	117
Illinois	728	420	167	9056507	16950	4.29	534
Indiana	294	128	22	3129755	5597	5.25	559
Kansas	74	36	14	1488525	2881	2.57	517
Kentucky	81	35	5	424266	3781	2.14	112
Louisiana	124	38	9	288453	4833	2.57	60
Massachusetts	128	48	20	1582349	12931	0.99	122
Maryland	289	51	18	799416	9965	2.90	80
Maine	8	4	2	34350	1244	0.64	28
Michigan	512	252	83	5550056	11928	4.29	465
Minnesota	116	34	12	470276	6301	1.84	75
Missouri	222	100	39	4877968	6633	3.35	735
Mississippi	49	12	3	98357	2143	2.29	46
Montana	41	19	5	315640	801	5.12	394
North Carolina	60	22	6	157832	6455	0.93	24
North Dakota	12	7	3	158639	658	1.82	241
Nebraska	40	15		28129	1915	2.09	15
New Hampshire	18	9	4	81349	1131	1.59	72
New Jersey	291	113	49	4461464	11469	2.54	389
New Mexico	36	10	5	267211	1436	2.51	186
Nevada	19	9	4	204487	642	2.96	319
New York	1195	473	279	22669161	43763	2.73	518
Ohio	485	251	66	4922511	14725	3.29	334
Oklahoma	82	31	11	355034	2929	2.80	121
Oregon	167	43	16	1124014	3428	4.87	328
Pennsylvania	877	267	106	7325641	18675	4.70	392
Puerto Rico	8	4	1	33300	2819	0.28	12
Rhode Island	33	17	9	747840	1686	1.96	444
South Carolina	18	6	1	29228	2931	0.61	10
South Dakota	15	6	3	146105	595	2.52	246
Tennessee	157	47	23	890644	5361	2.93	166
Texas	443	209	73	4826858	15829	2.80	305
Utah	44	24	8	360444	1745	2.52	207
Virginia	206	42	11	502241	7067	2.91	71
Vermont	19	11	5	313500	861	2.21	364
Washington	258	109	36	2288107	5641	4.57	406
Wisconsin	182	69	18	720818	5815	3.13	124
West Virginia	32	18	3	169523	1977	1.62	86
Wyoming	17	3	1	29200	372	4.57	78
.	117	30	6	257969			
*	11740	4742	1872	137261771	335977	3.43	409

Source: National Association of Insurance Commissioners: Malpractice Claims, Vol. 1, No. 3, September, 1976, p. 77.

CHART VI

TIME BETWEEN INCIDENT, REPORT AND DISPOSITION, BY STATE
JULY , [illegible] THROUGH AUGUST 15, 1976

	Incident to Report								Report to Disposition							
	Average Month		No. of Incidents		Average Month		No. of Incidents		Average Month		No. of Incidents		Average Month		No. of Incidents	
	Paid	Unpd.	Paid	Unpd.	Paid	Unpd.	Paid	Unpd.	Paid	Unpd.	Paid	Unpd.	Paid	Unpd.	Paid	Unpd.
Alaska					26	21	1	2	9	12	2	3	[illegible]			
Alabama	30	6	4	20	[illegible]	8	25	78	11	8	33	114	[illegible]			
Arkansas	4	30	3	4	[illegible]	11	9	21	16	17	16	27	7	[illegible]		21
Arizona	26	4	8	11	21	[illegible]	3	80	19	15	49	174	31	[illegible]	4	
California	15	12	98	145	14	13	872	970	23	17	1091	1308	31	[illegible]	[illegible]	[illegible]
Colorado	2	12	2	9	15	12	38	64	26	13	43	88	4	14	44	[illegible]
Connecticut	12	23	7	8	[illegible]	[illegible]	[illegible]	46	25	8	83	62	44	[illegible]	[illegible]	
District of Columbia	10	9	7	12	16	12	61	77	19	13	80	104	34	24	8	[illegible]
Delaware	53	7	3	8	4	10	9	18	14	12	13	28	26	14	[illegible]	48
Florida	14	9	22	34	12	10	152	234	14	9	197	306	26	18	[illegible]	316
Georgia	3	6	3	12	13	12	18	73	15	20	22	92	26	31	24	93
Hawaii		4		5	10	7	5	27	14	7	6	33	24	13	6	35
Iowa	15	84	9	4	13	11	27	19	16	9	45	26	29	31	45	29
Idaho	23	13	2	2	10	15	14	10	8	8	17	15	20	21	17	15
Illinois	24	8	48	42	16	12	336	237	24	12	418	303	40	24	416	308
Indiana	18	9	15	13	15	14	99	122	15	10	127	160	30	23	128	165
Kansas	33	26	6	4	20	15	28	28	14	16	36	35	36	31	36	38
Kentucky	9	7	5	6	11	9	28	32	17	14	35	44	27	19	35	45
Louisiana	22	7	5	10	11	8	32	69	23	19	38	85	34	27	38	86
Massachusetts	4	17	2	10	17	17	12	64	21	27	48	75	36	42	48	80
Maryland	18	9	10	27	14	10	35	156	19	10	48	205	32	19	51	238
Maine					13	11	4	4	14	18	4	4	26	28	4	4
Michigan	43	31	22	29	23	15	201	153	24	16	248	220	47	30	251	260
Minnesota	9	[illegible]	5	5	8	7	16	57	18	12	31	72	24	18	34	62
Missouri	12	12	15	12	13	12	79	98	19	14	100	119	31	26	100	121
Mississippi	2	5	4	4	15	14	5	31	7	14	11	37	18	24	12	37
Montana	21		4		10	20	15	18	19	14	19	22	31	35	19	22
North Carolina	44	9	3	5	13	5	17	18	19	8	21	24	35	12	22	38
North Dakota	1		1		12	5	6	4	14	11	7	5	25	20	[illegible]	5
Nebraska	14	13	5	2	15	15	10	19	15	10	15	23	30	24	15	25
New Hampshire	57		1		13	4	8	8	27	4	9	8	44	15	9	9
New Jersey	47	33	13	27	22	15	92	137	22	16	111	173	46	33	113	178
New Mexico					17	17	8	25	18	11	10	26	36	28	10	26
Nevada					13	13	9	9	25	19	8	10	33	26	9	10
New York	29	38	71	73	15	13	378	490	39	18	463	615	56	33	472	718
Ohio	18	24	39	36	14	13	193	151	20	14	248	212	34	28	251	235
Oklahoma	26	23	2	10	8	13	22	35	17	14	29	50	27	29	31	51
Oregon	24	10	3	9	10	10	36	98	12	8	43	124	23	18	43	124
Pennsylvania	21	9	36	39	17	10	196	238	21	10	261	311	38	14	2[illegible]	607
Puerto Rico	8	11	4	1		2		2	32	12	4	3	41	14	4	4
Rhode Island		23		3	14	17	16	12	33	15	17	16	45	56	17	16
South Carolina	13		2		15	28	4	7	8	8	6	10	22	23	6	12
South Dakota					8	11	6	9	12	17	6	9	20	29	6	9
Tennessee	31	7	5	8	9	11	34	65	21	18	45	87	32	24	47	110
Texas	17	16	38	26	14	13	159	183	19	17	206	231	33	30	209	234
Utah	8		1		26	14	18	20	6	10	24	20	31	23	24	20
Virginia	12	2	5	5	9	12	28	98	17	13	41	145	24	24	42	164
Vermont	4	24	2	1	15	9	9	7	25	11	11	8	38	22	11	8
Washington	19	41	12	13	14	18	81	100	13	8	108	146	26	28	109	149
Wisconsin	16	17	6	7	18	18	61	87	18	15	69	104	34	31	69	113
West Virginia					13	9	14	13	20	10	18	14	34	20	18	14
Wyoming	31	2	1	2	5	9	2	11	43	11	3	13	56	21	3	14
XX	1	7	1	4	11	7	13	43	18	8	24	74	27	14	30	86
**	21	17	562	702	15	12	3669	4679	22	14	4667	6147	37	25	4731	694

Source: National Association of Insurance Commissioners, Malpractice Claims, Vol. 1, No. 3, September, 1976, p. 11.

BASIC ISSUES AND PROPOSED SOLUTIONS

The main objective of the medical malpractice system is to provide adequate and reasonable compensation for those suffering medical injuries while encouraging diligence in the delivery of health care. The main constraint on achieving this objective is the consideration of cost. Decreasing availability and increasing costs are identified as basic elements addressed by proposed solutions to the medical malpractice problem. Prevention and quality assurance mechanisms also receive attention. The basic issue at the core of the medical malpractice insurance problem and the related suggestions for remedial action is, who shall pay for the ultimate cost of maintaining the medical malpractice system.

Major issues and the most frequently mentioned solutions from public testimony and from a review of the literature on medical malpractice are briefly outlined in this section. A definition is provided for each proposal and the important issues relating to the proposal are discussed. The treatment of these proposals is not intended to be totally comprehensive or exhaustive. The report merely serves as a guide to the basic issues and concerns raised by the most frequently offered solutions.

The proposals are divided into four general categories. The proposals in each category attempt to address a specific part of the medical malpractice problem.

A. PROPOSALS DESIGNED TO INSURE THE CONTINUED AVAILABILITY OF MEDICAL MALPRACTICE INSURANCE

Joint Underwriting Association (JUA)

The JUA is a pooling device composed of specified insurance carriers. The JUA is a short-term emergency measure to insure medical malpractice availability. It is an independent, temporary organization which may offer liability policies for health care providers who cannot obtain coverage in the private market. The underlying concept is to force insurers to provide medical malpractice coverage and share (pool) any resulting losses subject to recoupment. In exchange the insurers receive greater protection against unrecouped losses and retain the right to carry other more lucrative types of liability insurance in the state. Under most proposals, the JUA would become operative upon determination that medical malpractice insurance is becoming unavailable. Some proposals for creation of JUA make the pool self-supporting where premium rates are set high enough to cover expected losses. Others maintain medical malpractice premiums at an artificially low level by passing on any losses to holders of other types of insurance policies.

The JUA would guarantee the availability of medical malpractice insurance coverage for health care providers and would be a source

of compensation for injured health care consumers with no cost containment guarantees for health care providers. The pool would distribute the cost of medical injuries according to the financing mechanism established for initial capitalization. Health care providers could remain at risk, as is now the case, or insurers could be required to contribute. However, both insurers and providers could pass their costs on in their rates to their customers. Experience with JUA's in other states indicates that rates may increase rather than decrease. Depending upon how the fund is administered and financed, state government's role could vary. The implications of this concept could raise questions with other liability lines.

Self-Insurance

Under this approach selected health care providers would establish their own "captive" insurance company. Availability of coverage would be assured because health care providers would have control over the insurance company. It is argued that self-insurance would eliminate the credibility gap that presently exists over control of and access to claim experience data. Since health care providers as a group would assume all liability and be completely at risk for all costs resulting from medical injuries, a "captive" insurance company would create a strong economic incentive for health care providers to maintain claims at a minimum. Adequate initial capitalization and on-going fiscally sound administration would be the most difficult aspect of this proposal. A multi-state approach offers the likelihood of an actuarial sound universe of potential providers in need of liability coverage, however, the implementation would be extremely difficult and complex given a several state approach.

A solvent system of self-insurance would guarantee the availability of coverage for health care providers and a source of compensation for injured patients. Implementation of such a scheme would remove medical malpractice liability coverage from the traditional malpractice market. A "captive" insurer offers the potential for some cost savings to providers through the possible generation of administrative efficiencies and through investment earnings. The role of state government would be basically limited to a regulatory one.

B. PROPOSALS DESIGNED TO ENCOURAGE PREVENTION OF INJURIES AND INCREASE QUALITY OF HEALTH CARE.

Annual Registration Fee Increase

It is argued that the Montana State Board of Medical Examiners currently does not have adequate funding or staffing to effectively administer their mandated functions to insure that medical services rendered the citizens of Montana are of the highest possible quality. An increase in the authorized limit of the annual registration fee for licensed physicians to generate additional investigative capacity and enforcement is aimed at the quality assurance issue. The necessary amount of funding and the source of funding are areas of deliberation. At issue is whether and/or how to assure that the Board of Medical Examiners will have adequate resources to carry out its function. The need for a supplemental appropriation or the use of the medical fee is an area of concern. Accountability of the disciplinary process to the public is of paramount importance.

Reporting to Board of Medical Examiners

The State Board of Medical Examiners feels that it does not have sufficient sources of information with which to fulfill their quality assurance and disciplinary functions. Although current law allows a sworn statement to the Board concerning matters of competency and conduct, there is no requirement that information of medical malpractice claims and limitations on practice be reported to the Board. The effectiveness of medical practice review mechanisms depends on the flow of information concerning medical care to the reviewing entity. A mandatory reporting system would be a step towards an increase in physician accountability. The Board could become the central agent for safeguarding the quality of medical care, and investigating the resolving problems causing medical malpractice in Montana. The question of whether to consolidate collecting and information dissemination functions for all health care providers or to keep functions separate, with a different data center for each group is a issue of concern.

Strengthen Appropriate Licensing Boards

The appropriate health care licensing boards have a responsibility to the public to insure minimum standards of competence. Proponents of strengthening licensing boards argue that lack of a strong licensure mechanism may have left medical malpractice suits as a primary quality control mechanism. Although there may be no clear relationship between physician competence and medical malpractice claims, action to control the inadequate practitioner is urged as part of an overall program to reduce the incidence of medical malpractice claims. That disciplinary action against

practitioners found to be professionally incompetent be authorized and allowing boards the ability to limit the scope of practice of a practitioner as a disciplinary sanction against health care providers other than license suspension or revocation are among recommended measures to strengthen licensing boards. It is argued that licensing boards be authorized to restrict practice by time, specialty, procedure or facility and to be able to require continuing education or retraining.

Injury Prevention Programs in Health Care Institutions

Every health care institution, beginning perhaps with hospitals, should initiate patient injury prevention programs. These programs include such measures as the implementation of effective incident reporting systems to identify major causes of patient injury and related hazards, followed by corrective measures; continuous monitoring of quality of care provided; continuing education and safety training for personnel and implementation of standardized safety procedures.

Injury Prevention Programs for Insurance Carriers

Most insurance companies undertake loss-prevention or risk management programs for the various lines they carry. These efforts include the dissemination of printed information and films identifying safety hazards or potential risks. Increasing sophisticated risk-management or loss-prevention programs aimed at both injury and claims prevention and directed at individual providers as well as institutions have proven effective, especially when the insurance carriers have provided analyses to health care providers in order to aid in injury prevention programs.

C. *PROPOSALS DESIGNED TO REDUCE THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS.*

Statute of Limitations

In order to make medical malpractice losses more actuarily predictable, thus eliminating the "long tail" problem in insurance rate making, cutting off a cause of action based on a claim of medical malpractice after the expiration of a specified time period is proposed. In Montana the medical malpractice statute of limitations (Section 93-2624, R.C.M. 1947) is three years from the date of injury or date of discovery or when the injury should have been discovered through reasonable diligence, whichever occurs last, but in no case more than five years from the date of injury. The question of statute of limitations for minors is an especially sensitive area with the insurance industry and health care providers. In Montana the statute of limitations does not apply to minors until they have reached the age of majority. Special rules are urged to govern situations where medical malpractice misconduct is alleged in the case of a minor.

A major issue is the trade-off between an individual's right to seek compensation and the monetary and other costs of the existing medical malpractice system. Inasmuch as a shortened statute of limitations for minors would prevent people from suing because time had expired, claims and cost will be reduced. Health care provider and insurer liability would be lessened and premium rates could conceivably be lowered. It is, however, difficult to predict the degree of lowering that would result.

Res Ipsa Loquitur

This is a legal doctrine relating to the standard of proof in medical malpractice litigation, a doctrine in common law which literally means "the thing speaks for itself." It is used to establish liability without requiring demonstration of specific negligence. It consists of showing that a condition or injury could only have come about due to negligence and that the physician is the person who could have reasonably caused the injury. If these conditions are met, the burden of proof is shifted to the physician and he is forced to prove he was not negligent.

The doctrine as interpreted in Montana case law is not a problem in medical malpractice at this time. Concern that the doctrine not evolve to the interpretations being given in several other states may motivate some to seek that Montana case law be codified as it pertains to the burden of proof of res ipsa loquitur.

Restricting this doctrine would make it more difficult for patients to establish claims and would increase the importance of expert testimony and other types of evidence. More evidence would be required to establish a claim, and the evidence, in some instances might be difficult to secure. Thus is could reduce the number of claims awarded.

Ad Damnum Clause

An Ad Damnum clause is the part of the initial pleading in a lawsuit that states the amount of damages sought. This clause in the plaintiff's complaint that requests specific monetary damages is said to lead to unwarranted publicity and sensationalism, therefore increasing the likelihood of suits being filed. It may be argued that this practice results in suits for sums far in excess of what is expected and creates unfavorable publicity for a defendant. Any elimination of the Ad Damnum clause would probably have to provide for the jury, at the time of the trial, to learn the exact amount claimed so that determination can be made as to whether or not the amount exceeds insurance coverage.

Locality Rule

Traditionally, courts have required physicians to practice at the level of skill which is prevalent in their community. This "locality rule" seems to be weakening due to more stringent court requirements across the nation. Many jurisdictions are now requiring that national standards of care be exercised by physicians in all localities. Although this does not mean that all physicians must be as skillful as the best of their colleagues, it does mean that individual physicians must utilize the procedures prescribed by good medical practice even if those procedures are not generally used in their locality. The advantages of a return to local standards of care should be weighed against the contention that uniformity of training and pervasiveness of communications have created a national medical community, all members of which should be expected to exercise the same minimum level of care.

Collateral Source of Awards

Medical malpractice damages are awarded in part to cover the patient's medical expenses. Many times these expenses may already be covered by public or private insurance. Thus, it is agreed that damages on the amount of medical expenses involved can result in a double payment. The "collateral source rule" prevents the consideration of such other sources of reimbursement in awarding medical malpractice damages. This rule may stem from a belief that all malpractice damages are really punitive, and financial assistance from other sources should not alter the health care provider's responsibility to pay for errors. Many believe that the elimination of such rules would not only reduce the amount of money awarded in medical malpractice actions, but would also be more equitable in reimbursing the injured patient for actual expenses incurred. Others contend that the injured person should be compensated for pain and suffering, inconvenience, etc. and that the rule should be maintained.

Central to this issue is the question of who should pay the costs of medical injury. Decreasing a medical malpractice award by the amount of collateral sources would have the insured and the collateral sources pay a share of the injury -- an injury caused by neither of those parties. Requiring the court to consider all sources of payment or amounts payable to the plaintiff would result in reduced health care provider and insurer liability. It would also result in the injured paying more of their own costs and not receiving duplicative payment from medical malpractice awards and other compensation sources.

Advanced Payments

It has been proposed that advance payments in services and money by a health care provider or insurer to an injured patient prior to claim resolution not be accepted as evidence of provider admission of liability for injuries or damages suffered by the patient. The issue is whether the expeditious payment of money or medical services would result in less claims or less costly claims and whether this would be in the best interest of the potential plaintiff.

Allowing advance payments could reduce the frequency and/or the severity of claims and therefore the total costs associated with medical malpractice. It would reduce patient hardship immediately and could result in reduced claim costs by leading to early settlements. Disallowing advance payments as evidence of guilt would restrict the evidence available to the patient for establishing guilt, but would free health care providers with good intentions to help out without the fear of liability. Advance payments could provide the patient with a quick source of payment for immediate costs or services for which there is usually no other immediate source.

Structured Periodic Payments

This is one possible method of reducing the overall amount of medical malpractice costs. Currently, medical malpractice awards to those individuals requiring long-term care are granted in a lump sum based on life expectancy. Such a grant assures that the medical malpractice victim has adequate money to provide for future needs and care. Instituting periodic payments could result in an ultimate decrease in amount of awards paid out. The significance of such savings, however, may be found to be minimal. It could help assure that awards reach those for whom they are intended and could prevent windfall gains to dependents or relatives of award recipients. A structural periodic payment mechanism encourages damage awards to be used for the purposes intended and allows for modifications to be made in the payments in the event that conditions change.

Statute of Frauds/Agreements to Heal

These proposals seek to eliminate concern in the legal process over oral guarantee and would prohibit medical malpractice actions based on a contract theory unless there is written evidence of a contract. Thus, there would be no warranty of results unless the health care provider signs a document setting forth the terms of the warranty. This proposal raises the issue of whether any medical treatment guarantee can realistically be made.

In that the statute of frauds is rarely used as a basis for medical malpractice suits, altering it would have only a minimal impact on the overall claims picture. Requiring that only written guarantees be acceptable would eliminate virtually all claims based on a guaranteed result of treatment. The present patient basis for a claim would be restricted. It is unclear, however, how significant this restriction would be in light of the infrequent use of the present statute of fraud.

Notice of Claim Prior to Suit

The requiring of notice of intent to file suit prior to the commencement of a medical malpractice action could enhance the possibility of a settlement of the claim before the suit is filed.

Malicious Persecution

To the extent that "nuisance claims" are a problem in Montana that exacerbates the medical malpractice insurance situation, this proposal provides a remedy that would discourage unworthy claims.

Annual Report of Statistics to Insurance Commissioner

Requiring professional liability insurance carriers, as a condition of doing casualty business in the state, to include in their annual statement to the Insurance Commissioner certain statistics and information attempts to combat the dearth of useful data on the true medical malpractice experience in Montana. There is a need to examine critically the insurance premium rates charged by medical malpractice insurance carriers in the state. Currently, insurance companies are under no obligation to report certain malpractice data. Analysis and definition of the alleged problem remains difficult without adequate and timely information. Insurance information has been difficult to obtain.

Mandatory Insurance Coverage

Mandatory proof of health care providers financial responsibility through the purchase of medical malpractice liability insurance or the depositing of a specified sum with the Insurance Commissioner is urged as methods to assure all citizens that funds will be available to compensate them in the event they become victims of medical malpractice. Requiring all physicians practicing in Montana to be covered by medical malpractice insurance seeks to counteract the recent phenomenon of physicians "going bare", -- carry no medical malpractice insurace.

D. PROPOSALS DESIGNED TO CHANGE THE CURRENT SYSTEM OF ADJUDICATION

Contract Arbitration

The use of voluntary contractual arbitration of medical malpractice claims is the most frequently offered alternative to the tort system. It would provide for written agreements, entered into voluntarily, which would stipulate the submission of medical malpractice claims to an impartial panel for final determination. Such agreements are binding on the parties, enforceable under law and a substitute for a court trial. Voluntary arbitration is seen as a method to expedite claims and reduce the cost of the process. The presence of an arbitration scheme could enhance the access of the injured to compensation for smaller claims settlement. Arbitration would probably lower the time costs of claims adjudication. Health care providers would continue to need medical malpractice insurance and the costs for such insurance would continue to be high until and unless experience proves that the costs to insurers of arbitration are less than for the tort system.

The efficacy of some form of voluntary and binding arbitration is dependent on the arbitrators. The question of who should be arbitrators is an issue to be resolved. There is concern that arbitration results might reflect an unbalanced view. Concern is expressed that any arbitration scheme should include a process by which all (particularly low-income claimants) could be guaranteed legal counsel. Balanced against considerations of the economy and speed associated with arbitration schemes, however, are questions of individual rights. The individual's right to trial by jury is fundamental to American justice. If arbitration should become compulsory and binding without appeal, its affect upon the jury trial will be significant. If appeal is readily allowed, the value of the arbitration process as an alternative to the current system of adjudication may be lessened.

Mandatory Pre-Trial Screening Panels

A popular device for resolving medical malpractice claims without going to trial is the screening or mediation panel. A mandatory pre-trial screening panel would establish legal framework that may reduce the number of cases which end up in court. Theoretically, the screening panel is designed as a neutral body of experts who hear both sides of the dispute and based on the evidence presented recommend that the issue be settled or withdrawn. Mandatory pre-trial screening panels are very similar to arbitration schemes. Proposals set guidelines for the composition of the panel, the type of evidence it can hear, and the qualifications of its members.

Screening panels could expedite the process of resolving claims by discouraging claims without merit and by encouraging settlements of claims with merit. Inasmuch as the panel reduces claims frequency by discouraging claims and succeeds in encouraging settlements, total costs associated with medical malpractice could be reduced. Settled claims with claimant payment usually costs less than litigated cases leading to payment. Screening panels could increase the access of injured to compensation for smaller claims. The efficacy of panels would depend on the makeup of the panel. There is potential that pre-trial review panels could reflect an unbalanced viewpoint. Insurance companies have been reluctant to participate in screening panel schemes viewing such panels as detrimental, inasmuch as they are caused to reveal their defense while facing a possible court action.

A screening or mediation panel creates another layer of judicial procedure. If it leads to a settlement, then it is a quicker and far less costly procedure. If it fails, then it adds to the already high cost of handling medical malpractice cases.

Fixed Compensation -- Workers' Compensation

It is proposed by some that a form of compensation similar to that of workers' compensation be designed for all or limited types of medical injuries. Under such a system the emphasis would be on equitable compensation for injury. The issue of causation or negligence would not be addressed. This mechanism would facilitate and guarantee patient compensation but could lead to an increased number of claims and additional costs. However, the cost per claim would be fixed and predictable. Proponents view compensation as an opportunity to eliminate the adversary relationship between provider and patient and reduce the number of cases going to court.

Health care provider and general liability for medical injuries would vary dependent on the financing mechanism. The amount and nature of assessment for the fixed compensation fund or payments would define liability for payment. Whether an assessment of health care providers, a public tax, or some other funding mechanism remains a key issue of concern under this proposal.

SELECTED BIBLIOGRAPHY

Aetna Life and Casualty, Montana Medical Association Professional Liability Insurance Program, October 1975.

Andrew, Stephen L., "Malpractice Suits: The Increased Cost of Health Care", Tulsa Law Review Vol. 8, No. 2, 1972.

Association of Trial Lawyers of America, Trial: The National Legal Magazine, Cambridge, Massachusetts, May-June 1975, issue is devoted to medical malpractice.

Bernzweig, Eli P., "The Malpractice Equation: A Conceptual Tool for Analyzing the Malpractice Problem", Special Advisory Panel on Medical Malpractice, State of New York, October 7, 1975.

Christianson, Jon B. and Hill, P.J., "Malpractice and Risk: The Contractual Alternative", Staff Papers in Economics, Montana State University, Bozeman, Montana, 1975.

Council of State Governments, "The States and Medical Malpractice", Research Briefs, Lexington, Kentucky, July 18, 1975.

Defense Research Institute, Inc., "Medical Malpractice Position Paper", Volume 1974, No. 6, Milwaukee, Wisconsin, 1974.

Denenberg, Herbert S., "The Medical Malpractice Mess", The Progressive, 1975.

Derbyshire, R.C., Medical Licensure and Discipline in the U.S., 1969.

Derbyshire, R.C., "Medical Ethics and Discipline", 228 Journal of the American Medical Association, April 1, 1974.

Duke Law Journal, Vol. 1975, No. 6, January 1976, issue is devoted to medical malpractice.

Forbes, "A Close Call", pp. 30-36, April 15, 1976.

Fulton, Alfred M., M.D., "The Medicolegal Screening Panel", Rocky Mountain Medical Journal, May, 1973.

Gibbs, G. Geoffrey, "The Montana Plan for Screening Medical Malpractice Claims", Montana Law Review, Vol. 36, 1975.

Havighurst, Clark C. & Blumstein, J., "Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSRO's", 70 Northwestern University Law Review, 1975.

Havighurst, Clark C. and Tancedi, Lawrence R., "Medical Adversity Insurance - A No-Fault Approach to Medical Malpractice and Quality Assurance", Milbank Memorial Fund Quarterly, Vol. 5, No. 2, Spring 1973.

Health Systems Research Institute, Intermountain Medical Malpractice Seminar, May, 1976, DHEW Publication No. (HRA) 76-3150.

Health Policy Analysis Program, "The Malpractice Issue in Washington", Department of Health Services, University of Washington, Seattle, Washington, November, 1975.

Heintz, Duane H., "Study Points to the Potential of Arbitrating Malpractice Claims", Hospitals, Vol. 50, April 16, 1976.

Heintz, Duane H., "Arbitration of Malpractice Claims: A Hospital Based Pilot Project", Inquiry, Vol. XIII, No. 2, June 1976.

Hendricks, James D., "How Malpractice Premiums get so Big", Medical Economics, April 19, 1976.

Henahan, John F., "Malpractice", Atlantic Monthly, April, 1976.

Hershey, Nathan, "The Defensive Practice of Medicine - Myth or Reality", Milbonha Memorial Fund Quarterly, Vol. 1, January, 1972.

Keeton, Robert E., "Compensation for Medical Accidents", University of Pennsylvania Law Review, Vol. 121, January, 1973.

Kleinman, Kenneth W., "PSRO: Malpractice Liability and the Import of the Civil Immunity Clause", The Georgetown Law Journal, 62, 1974.

Lerner, Richard E., "A Survey and Critique of 1975 Legislation Providing for Arbitration and Mediation of Medical Malpractice Claims", American Arbitration Association, New York, November 18, 1975.

Macro Systems, Inc., "Medical Malpractice - A Selected Annotated Bibliography", A report to: Division of Health Care Systems, Office of Policy Development and Planning, Office of the Assistant Secretary for Health, DHEW, April, 1975.

Medical Malpractice, Report of the Secretary's Commission on Medical Malpractice, Department of Health, Education and Welfare, Washington, D.C., DHEW Publication, November (05), 73-88, January 16, 1973.

McDonald, Donald, Medical Malpractice: A Discussion of Alternative Compensation and Quality Control Systems, Santa Barbara, California, Center for the Study of Democratic Institutions, November, 1971.

Office of Legislative Research, State of Utah, "Medical Malpractice Insurance Problems: Report to the 41st Legislature", January, 1976.

Report of the Secretary's Commission on Medical Malpractice, Washington, U.S. Department of Health, Education, and Welfare, 1973 DHEW Publication No. (05), 73-88.

Rubsamen, David S., "Medical Malpractice", Scientific American, Vol. 235, No. 2, August, 1976.

Saypol, George M, M.D., "Medical Malpractice: Threat to Quality Care", New York State Journal of Medicine, February, 1976.

Schmidt, Herman E., "Medical Malpractice: A Survey of Associated Problems and Proposed Remedia", Library of Congress, Congressional Research Service (R724-75-3ED), January 15, 1975.

Stetler, C. Joseph L. M., "The History of Reported Medical Professional Liability Cases", Temple Law Quarterly, Vol. 30, 1957.

The Center Magazine, "Medical Malpractice", Center for the Study Of Democratic Institutions, July/August, 1975.

U.S. Commission on Medical Malpractice, "Appendix: Report on the Secretary's Commission on Medical Malpractice", Washington, Department of Health, Education, and Welfare, 1973 DHEW Publication No. (05) 73-89.

U.S. Congress, House of Representatives, Committee on Interstate and Foreign Commerce, "An Overview of Medical Malpractice", Washington, U.S. Government Printing Office, March 17, 1975.

U.S. Congress, Senate Subcommittee on Executive Reorganization, Committee on Governmental Operations, "Medical Malpractice: The Patient Versus the Physician", Washington, U.S. Government Printing Office, November 20, 1969.

Warren, David G. & Merrit, Richard, "A Legislator's Guide to the Medical Malpractice Issue", Health Policy Center, Georgetown University National Conference of State Legislatures, Washington, D.C. 1976.

Weiss, Sophie Carroll, "Medical Quality and Patient Outcomes: Malpractice in Perspective", Tax as Legislative Council, Staff Report, April 15, 1976.

Welch, Claude E. M.D., "Medical Malpractice", The New England Journal of Medicine, June 26, 1975.

Malpractice

If a physician fails to make a properly skillful and careful diagnosis and makes an incorrect diagnosis, he may be held liable to patient for damage thus caused.

Doerr vs. Movius
463 P (2d) 477 (1970)

A fundamental duty of a physician is to make a properly skillful and careful diagnosis of ailment of a patient, and if he fails to bring to that diagnosis the proper degree of skill or care, and makes an incorrect diagnosis, he may be held liable to patient for damage thus caused just as readily as he must answer for application of improper treatment.

Unauthorized operation. While an unauthorized operation is, in contemplation of law, an assault and battery, it also amounts to malpractice, even though negligence is not charged.

"Malpractice", also sometimes called "malapraxis" means bad or unskillful practice, resulting in injury to patient, and comprises all acts and omissions of physician or surgeon as such to a patient as such, which may make physician or surgeon either civilly or criminally liable.

Bakewell v. Kahle
125 Mont 89 (1951)

A physician or surgeon is not necessarily liable for malpractice because of a bad result in treating a patient.

A physician or surgeon is not liable for injuries in treating a patient, arising, without negligence, from honest errors in judgment.

A physician is not bound to employ any particular method in treatment of a patient, and, where among physicians of ordinary skill and learning more than one method of treatment is recognized as proper, it is not negligence for him to adopt either of such methods.

Mere fact that there are other methods of treatment than the one employed by a physician, or that other physicians would have used or advised use of different methods in particular case, is not proof of negligence.

Dunn v. Beck
260 P 1047 (1927)

Error of judgment on the part of a physician or surgeon resulting in an incorrect diagnosis of a disease or injury does not alone render him liable in damages; nor does the fact that others might have adopted a different method of treatment convict him of negligence or want of skill or care; but if the method adopted has substantial medical support, it is sufficient.

Schumacher v. Murray Hospital et al
58 Mont 447 (1920)

Medical Persons' Legal Obligations

A bad result alone does not constitute evidence or raise a presumption or inference of negligence in a medical malpractice case.

Montana Deaconess Hospital v. Gratton
545 P. (2d) 670 (1976)

...the mere fact she suffered an injury is not enough. The law does not presuppose that for every injury there must be a recovery in damages. For the plaintiff to recover there must be a breach of a legal duty owed to her by defendant, which proximately caused her injury.

Collins v. Itoh
160 Mont 461, 503 P.(2d) 36 (1972)

A physician or surgeon must possess skill and learning possessed by average members of medical profession in good standing and apply such skill and learning with ordinary and reasonable care.

A physician or surgeon is not an insurer, his obligation being merely to exercise such reasonable care and skill in treatment of patients as is exercised by physicians or surgeons of good standing, of same school of practice in community in which he resides, with due regard to patient's condition and practice of medical or surgical science at the time.

Dunn v. Beck
260 P 1047 (1927)

A surgeon agreeing to perform an operation is not a guarantor of a successful outcome, the law requiring of him no more than that he possess the skill and learning possessed by the average member of the medical profession in good standing in the community in which he resides, and to apply that skill and learning with ordinary and reasonable care.

Wilson v. Blair
65 Mont 155 (1922)

Held, that it was error to refuse defendants' offered instruction that a physician or surgeon is not bound to use any particular method of treatment, and that if among practitioners of ordinary skill and learning more than one method of treatment is recognized as proper it was not negligence for defendants to adopt either of such methods.

Schumacher v. Murray Hospital
et al
58 Mont 447 (1920)

Hospitals' Responsibilities and Privileges

Hospitals have the power to grant and revoke privileges of staff membership in accordance with fair rules and regulations.

North Valley Hospital vs. Kauffman
544 P (2d) 1019 (1976)

Private hospital has right to prescribe terms on which it offers its services to public as long as hospital does not discriminate against some patient in providing those services. Statute which provides that "Physicians shall continue to have direction over his patients, subject to private hospital's rules and regulations based on religions or moral tenets."

Ham vs. Holy Rosary Hospital
529 P (2d) 361 (1974)

A hospital conducted for private gain is not an insurer of its patients against injuries inflicted by themselves; it is only required to use ordinary and reasonable care and diligence in their treatment and care; where, however their mental or physical condition is such as to disable them to look after their own safety, the degree of care given them must be proportionate to such condition.

It is the duty of a hospital conducted for gain to use reasonable care to employ only competent physicians and nurses, the skill required of them being such as is possessed by others similarly engaged in like communities.

If physicians or nurses in a hospital discovered, or by the exercise of reasonable care and skill should have discovered, that the mental condition of a patient was such at any time before he inflicted an injury upon himself that it might reasonably have been anticipated that he would act as he did, it was the duty of the hospital to see that that degree of care was used to have him watched or kept under observation to prevent the injury which ordinarily skillful, careful and prudent persons engaged in treating and caring for persons in his condition would have used.

Maki v. Murray Hospital
91 Mont. 251 (1932)

Those Subject to Malpractice Suits

In malpractice action the law as applies to physicians, surgeons, dentists and the like, applies to chiropractors.

Bakewell v. Kahle
125 Mont. 89 (1951)

A dentist in the conduct of his profession is governed by rules applicable to a physician and surgeon in respect to the degree of care and shall be required in the treatment of a patient.

Donathan v. McConnell
121 Mont. 230 (1948)

Licensure of Medical Persons

Applicant for license to practice medicine in state has burden to supply Medical Board of Examiners with the necessary information and it is the duty of Board to investigate such information to determine if applicant is qualified.

Shelton vs. Board of
Medical Examiners
534 P (2d) 870 (1975)

Charges of unprofessional and unethical conduct made by Board of Medical Examiners against a physician relating to overcharges for services not performed, an attempted abortion, unauthorized removal of X-rays, and encouragement of fraudulent claims before Industrial Accident Board for injuries not actually suffered, were not outside scope of jurisdiction committed to the state board by statute authorizing the board to revoke the certificate of a physician and surgeon for unprofessional, dishonorable or immoral conduct.

The State Board of Medical Examiners had exclusive jurisdiction in the granting and revoking of certificates admitting physicians and surgeons to practice, and in view of fact statutes do not provide for disqualification of board, members, proceedings before the board may not be restrained merely by reason of fact that board member initiated that proceedings against a physician and was therefor an interested party.

State vs. Board of Medical
Examiners
135 Mont. 381 (1959)

The Doctrine of Locality Rule

The custom and practice of one particular doctor, without knowledge of the general custom and practice among the profession, cannot establish a reasonable basis to infer that defendant departed from that practice. Nor does it infer that a doctor who does not follow that particular practice was negligent.

Considered "locality rule" but said it was not raised in this case.

Held that requiring doctors to perform operations only when pathologist in residence "would place an intolerable burden upon

small hospitals and doctors living in small communities."

Collins v. Itoh
160 Mont. 461, 503 P.2d 36
(1972)

Fact that operation on minor plaintiff failed to reveal a hernia as previously diagnosed by defendant physician, with result that plaintiff was left with two scars on her lower abdomen, was not sufficient to establish a prima facie case of negligence against defendant, absent a showing that defendant acted without ordinary care, diligence and skill, that he did not make a proper and skillful diagnosis, or that he deviated from established proper medical procedure as practiced in his neighborhood.

Doerr v. Movius
463 P(2d) 477 (1970)

A dentist assumes toward patient the obligations to exercise such reasonable care and skill as is usually exercised by a dentist in good standing of the community in which he resides.

Donathan vs. McConnell
121 Mont. 230 (1948)

The Doctrine of Informed Consent

Duty of physician to disclose in order to assure that an informed consent is obtained from patient is limited to those disclosures which a reasonable practitioner would make under similar circumstances; accordingly, if physician obtains an informed consent and proceeds as a competent medical man would in a similar situation, his course of action should not be questioned.

Doctrine of an informed consent on part of patient or one acting in patient's behalf was not applicable to situation wherein minor plaintiff underwent a simple operation for repair of a supposed hernia to which mother had previously given her written consent, even though a failure to find a hernia on plaintiff's left side as previously diagnosed necessitated the opening of plaintiff's right side, since there were no dire consequences to be suffered as a result of opening child's right side, the worst possible consequence being the creation of a small needless scar in a generally covered area of the body.

Doerr vs. Movius
463 P(2d) 477 (1970)

Gist of the "informed consent" theory of liability is that a physician is under a duty under some circumstances to warn his patient of the known risks of proposed treatment so that the patient will be in a position to make an intelligent decision as to whether he will submit to such treatment.

In order for patient to be held to have given an intelligent consent to proposed treatment the physician must have to disclose those consequences of treatment which reasonable medical practitioner would disclose under the same or similar circumstances, and how physician may best discharge his obligation to patient involves primarily a question of medical judgment, and so long as disclosure is sufficient to assure an informed consent the physician's choice of plausible courses should not be called into question if it appears that physician was motivated only by patient's best therapeutic interest and proceeded as competent medical men would have done in a similar situation.

Liability of dentist, who fractured mandible of patient while extracting tooth, could not be predicated upon the doctrine of "informed consent" where, *inter alia*, there was no showing that dentist knew prior to or during the extraction that there was insufficient buccal plate left to withstand the pressure necessary to extract the wisdom tooth.

Question of what disclosure of risks incident to proposed treatment is required to be given by a dentist to his patient under given circumstances must be established by expert testimony.

Liability of defendant dentist could not be predicated upon "informed consent" theory of liability where, *inter alia*, patient failed to establish a standard of dental conduct with reference to what was required in the way of disclosure.

Negaard v. Feda
152 Mont. 47 (1968)

Rules of Evidence and Testimony in Malpractice Cases

Doctors' admission of negligence proof of negligence.

Thomas vs. Merriam
135 Mont. 121 (1959)

In actions against physicians, surgeons, or dentists, expert medical testimony is not essential where the suit is predicated upon ordinary negligence and not upon lack of professional skill or care in treatment.

Kelly vs. McCabe (1944)
146 P(2d) 770, 115 Mont. 550

Defendants' requested instruction that the question whether or not they exercised reasonable and ordinary care and skill in the treatment of decedent was to be determined from the expert testimony of physicians and surgeons alone, held properly refused as taking from the jury consideration of the evidence of lay witnesses concerning conditions upon which their testimony was relevant and material.

Schumacher v. Murray Hospital et al
58 Mont. 447 (1920)

Doctrine of "Res Ipsa Loquitur"

This doctrine is inapplicable in the ordinary malpractice action.

The elements necessary for the application of *res ipsa loquitur* are as follows: (1) The instrumentality which caused the injury must be within the exclusive control of the defendant; (2) the injury must be one that does not ordinarily occur if the party in control uses proper care; (3) the injury must not be due to any fault on the part of the injured person.

The doctrine of *res ipsa loquitur* is not applicable in a malpractice action from the mere fact that an infection developed in the area of treatment.

Montana Deaconess Hospital vs. Gratton
545 P.(2d) 670 (1976)

While this is a malpractice action, the rules relating to burden of proof in civil actions...are applicable. Plaintiff has the burden of establishing the breach of duty on the part of the physician and surgeon.

The doctrine of *res ipsa loquitur* does not apply where two reasonable inferences may be drawn from the evidence: First that the defendant was negligent; and, second, that some third person may have been negligent.

Vonault v. O'Rourke
97 Mont. 92 (1933)

Where, in an action against a hospital for personal injuries to plaintiff while a patient therein sustained by him in jumping from a third-story window under the impulse of delirium, the complaint made allegations of negligence so general as to cover any act of omission or commission on the part of the hospital staff toward him from the time of his entry until the moment he jumped, and in making proof relied upon the doctrine of *res ipsa loquitur*, as defined in paragraph 5 below, i.e., proof as general in character as set forth in the complaint, the district court erred in refusing instructions based on such doctrine, and in giving one narrowing the issues to one act of negligence to the exclusion of others pertaining generally to the care and attention which his condition required.

While in every personal injury action the plaintiff has the burden of proving actionable negligence on the part of defendant, where the injury was sustained under such circumstances or by reason of instrumentalities under the exclusive control or operation of the latter, thus making it impossible for plaintiff to know or prove the facts showing negligence, but it is clear from common knowledge and experience that the accident would not have happened, ordinarily, if defendant had not been negligent, the doctrine of *res ipsa loquitur* applies: a presumption of fact

arises that the injury was due to defendant's negligence, which, in the absence of explanatory evidence rebutting the presumption with such certainty as to preclude any other reasonable hypothesis, makes a prima facie case for plaintiff sufficient to go to the jury.

Held, that the doctrine of *res ipsa loquitur*, as above defined, applies in an action against a hospital for injuries sustained by a patient through alleged carelessness or lack of skill of its medical and nursing staffs in permitting plaintiff, while in a delirious condition, to inflict injuries upon himself, and that the trial court erred in instructing the jury that plaintiff was required to prove negligence (which proof is supplied by the doctrine), and that the law presumed that he was not negligent (though proper in the ordinary personal injury action).

Maki v. Murray Hospital
91 Mont. 251 (1932)

Application of the *res ipsa loquitur* doctrine in a personal injury action does not dispense with the rule that plaintiff must prove actionable negligence, the phrase meaning no more than that where the circumstances attendant upon the accident are of themselves of such a character as to justify a jury in inferring negligence as the proximate cause of the accident, they may indulge such inference; when properly applied, the doctrine operates to make out a prima facie case, and goes no further.

The doctrine of *res ipsa loquitur* is applied where the defendant was in the management and control of the instrumentality which caused the accident and the attendant circumstances are such as to raise a presumption that it would not have occurred had the defendant used reasonable care, and on the theory that plaintiff is not in a position to show the circumstances, but that defendant, being more favorable situated, possesses the knowledge of the cause of the accident and should be required to produce the evidence in explanation.

Negligence may be proved by circumstantial evidence; in such case the circumstances must not only tend to prove negligence and that such negligence was the proximate cause of the injury, but must also tend to exclude any other reasonable conclusions, it being sufficient, however, to make out a prima facie case, to show that the injury is more naturally attributable to the negligence alleged than to any other cause which the evidence might also tend to establish.

Negligence may be charged in general terms, and especially so where plaintiff relies upon the doctrine of *res ipsa loquitur*; hence, in an action to recover damages from a surgeon for malpractice resulting in a burn upon the chest of plaintiff during the time she was under the influence of an anesthetic, in which plaintiff availed herself of the doctrine, the complaint alleging

that defendant did not use due or proper care during and after the operation, in the treatment, etc., was sufficient as against a general demurrer.

The doctrine of *res ipsa loquitur* has no application to the ordinary malpractice case where the physician or surgeon is sought to be held in damages for alleged improper treatment in the course of an operation, but may be availed of where, through the operation was entirely successful, injury occurred from an incidental act or omission through carelessness or lack of skill which the patient is unable to prove because then unconscious from the effects of the anesthetic.

Where the doctrine of *res ipsa loquitur* is applicable in a personal injury action, it operates to establish a prima facie case of negligence, which, if unexplained, carries the question to the jury--it raises a rebuttable presumption that defendant was negligent.

The rebuttable presumption created by the application of the doctrine of *res ipsa loquitur* is indirect evidence, and though the maxim does not alter the general rule that in a personal injury action the burden is upon plaintiff throughout to prove the negligence complained of, he may establish his case by indirect or circumstantial evidence, and unless the circumstances relied upon are so satisfactorily explained by defendant that they point to freedom from negligence as to preclude any other reasonable hypothesis, the cause should be submitted to the jury.

Vonault v. O'Rourke
97 Mont. 92 (1934)

The rule *res ipsa loquitur* goes no further than to make out a prima facie case; it has the force and effect of a disputable presumption and cannot exist where facts are known and where from the evidence different inferences may be drawn as to the producing cause of the injury.

Where plaintiff had produced evidence sufficient to make out a prima facie case of the negligence alleged in her complaint, she could not in addition invoke the doctrine of *res ipsa loquitur*, since such a course would have permitted the jury to give double weight to the evidence, to the facts as shown, and to the inference or presumption deduced by the law from the existence of those facts.

Lyon v. Chicago, Milwaukee & St. P. Ry. Co.
50 Mont. 532 (1915)

Admissibility of Evidence on Physicians' Insurance Coverage

The rule in Montana is the rule which has been adopted in most of

the states of the Union. If counsel for defendant asks if doctor has malpractice insurance and this influenced jury--then it is grounds for reversal.

In the light of the record in this case and because the matter of insurance coverage will unquestionably arise frequently in the future, under the common practice of relying upon indemnity and accident insurance now generally in vague, we feel that it is important that this principle (that the defendant may not be questioned about insurance) be safeguarded.

Vonault v. O'Rourke
97 Mont. 92 (1934)

The conduct of counsel for plaintiff in bringing to the attention of the jury by questions and argument matter tending to show that defendant surgeon would not himself have to pay any damages that might be awarded, since he was protected by a bonding company, held, not commendable.

Wilson v. Blair
65 Mont. 155 (1922)

Statute of Limitations

Doctrine of fraudulent concealment was not applicable to medical malpractice case in which plaintiff alleged that doctor had failed to make a full disclosure of the experimental nature of the operation to be performed but admitted that he was informed in detail of the type of operation to be performed and that he consented to the operation and where, although doctor assured plaintiff that he would be able to return to work within six months of the operation, plaintiff admitted to being totally disabled for six years after the operation and partially disabled thereafter.

Monroe v. Harper
518 P 2d 788 (1976)

RECENT MALPRACTICE LEGISLATION*

State-By-State Summary of Recent Legislation Related to Medical Malpractice**

State and Bill Number	Type of Legislation	Effective Date
Alabama		
H.B. 165	Peer Review -- Quality of Care Reform	5/02/75
H.B. 300	Ad Damnum Clause	9/23/75
"	Advanced Payments	"
"	Arbitration Agreements	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Periodic Payments	"
"	Standard of Care	"
"	Standby JUA	"
"	Statute of Limitations	"
S.B. 106	Good Samaritan Law	10/10/75
S.B. 473	Peer Review -- Committee Immunity (Dentists)	10/10/75
Alaska		
H.B. 574	Ad Damnum Clause	5/28/76
"	Advanced Payments	"
"	Arbitration Agreements	"
"	Collateral Source Rule	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Informed Consent	"
"	Good Samaritan Law	"
"	Mandatory Insurance Coverage (Chiropractors, Dental Hygienists, Dentists, Hospitals, Physicians, Psychologists, Physical Therapists, Pharmacists, Nurses, Optometrists)	"

*This summary and the glossary which follows were prepared by the National Association of Insurance Commissioners and are contained in their report entitled NAIC Malpractice Claims. Reprinted by permission.

**This summary includes only those bills which were passed or which became effective between January 1, 1975 and August 15, 1976. For an explanation of the terms used to describe the type of legislation enacted by the states, see the Glossary following this summary.

State and Bill Number	Type of Legislation	Effective Date
Alaska(cont.)		
H.B. 574	Peer Review -- Committee Immunity	5/28/76
"	Peer Review -- Continuing Education (Physicians)	"
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
"	Pre-Trial Panel (Voluntary)	"
"	Residual Malpractice Insurance Authority	"
"	Standard of Care	"
"	Standard of Proof	"
"	Standby JUA	"
"	Statute of Frauds/Agreements to Heal	"
Arkansas		
H.B. 530	Peer Review -- Committee Immunity	2/18/75
"	Peer Review -- Discovery of Committee Files	"
H.R. 33	Malpractice Study Authorized	2/26/75
S.B. 310	Reporting Malpractice Claims by Physicians	3/03/75
S.B. 236	Peer Review -- Committee Immunity	3/28/75
S.B. 311	Pre-Trial Panel (Voluntary)	3/28/75
H.B. 568	Professional Liability Reinsurance Exchange	4/03/75
H.J.R. 17	Limitation of Liability	1/28/76
Arizona		
H.B. 2001	Health Care Mutuals Authorized	2/27/76
"	JUA	"
"	Ad Damnum Clause	"
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Discovery of Patient Medical Files	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Continuing Education	"
"	Peer Review -- Discovery of Committee Files	"

State and Bill Number	Type of Legislation	Effective Date
Arizona (cont.)		
H.B. 2001	Peer Review -- Quality of Care Reform	2/27/76
"	Pre-Trial Panel (Mandatory)	"
"	Standard of Care	"
"	Standard of Proof	"
"	Statute of Frauds/Agreement to Heal	"
"	Statue of Limitations	"
California		
A.B. 4467	Ad Damnum Clause	1/01/75
S.B. 491	Standby JUA	5/23/75
A.C.R. 83	Malpractice Study Authorized	6/20/75
A.B. 1	Arbitration Agreements	12/12/75
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Limitation of Liability	"
"	Malpractice Insurance Rates	"
"	Notice of Claim Prior to Filing Action	"
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
"	Periodic Payments	"
"	Standard of Care	"
"	Statute of Limitations	"
S.B. 24	Amendments to Recent JUA Legislation	9/24/75
S.B. 24	Amendments to Recent Malpractice Legislation	12/12/75
A.B. 36	Data Submitted to Commissioner on Malpractice Claims Filed (Contents of Claims Reports)	1/01/75
S.B 589	Discovery of Patient Medical Files	1/01/76
S.B. 1124	Peer Review -- Discovery of Committee Files	1/01/76
S.B. 70	Good Samaritan Law (Search and Rescue Operation)	1/01/76
S.B. 1432	Declaratory Judgments Allowed	6/04/76
Colorado		
S.B. 362	Mandatory Insurance Coverage (Medical Professional Service Corporations)	7/01/75

State and Bill Number	Type of Legislation	Effective Date
Colorado (cont.)		
S.B. 252	Peer Review -- Committee Immunity	7/01/75
"	Peer Review -- Quality of Care Reform	"
H.B. 1012	Peer Review -- Committee Immunity (Hospital Trustees)	4/02/76
"	Peer Review -- Discovery of Committee Files	"
H.B. 1208	Peer Review -- Committee Immunity (Amendment)	4/19/76
H.B. 1146	Informed Consent	4/30/76
H.B. 1011	Malpractice Insurance Rates	5/07/76
H.B. 1061	Standby Insurance Pool/Plan	5/07/76
H.B. 1006	Mandatory Insurance Coverage	5/21/76
H.B. 1014	Standby JUA	5/27/76
S.B. 23	Statute of Limitations	5/27/76
H.B. 1009	Data Submitted to Commissioner on Malpractice Claims Filed	7/01/76
Connecticut		
H.B. 7276	Malpractice Study Authorized	6/12/75
S.B. 1496	Good Samaritan Law (Lifeguards and Policemen)	6/26/75
H.B. 5128	Good Samaritan Law (Ski Patrol)	10/01/75
S.B. 508	Advanced Payments	10/01/76
S.B. 510	Standard of Proof	10/01/76
S.B. 506	Mandatory Insurance Coverage	10/01/76
S.B. 56	Peer Review -- Committee Immunity	10/01/76
"	Peer Review -- Discovery of Committee Files	"
S.B. 434	Peer Review -- Quality of Care Reform	1/01/77
Delaware		
S.B. 578	Advanced Payments	4/26/76
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Informed Consent	"
"	Malpractice Study Authorized	"
"	Periodic Payments	"
"	Peer Review -- Quality of Care Reform	"
"	Pre-Trial Panel	"

State and Bill Number	Type of Legislation	Effective Date
Delaware (cont.)		
S.B. 578	Punitive Damages (Allowed)	4/26/76
"	Standard of Care	"
"	Standard of Proof	"
"	Standby JUA	"
"	Statute of Frauds/Agreements to Heal	"
"	Statute of Limitations	"
Florida		
H.B. 1267	Ad Damnum Clause	5/20/75
"	Informed Consent	"
"	JUA	"
"	Limitation of Liability	"
"	Malpractice Study Authorized	"
"	Patient's Compensation Fund	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Quality of Care Reform	"
"	Pre-Trial Panel (Voluntary)	"
"	Statute of Frauds/Agreements to Heal	"
"	Statute of Limitations	"
H.B. 2825, 3042, 3043, 3044, 3155	Discovery of Patient Medical Files (Right of Insurer)	10/01/76
S.B. 586	Collateral Source Rule	7/01/76
"	Limitation of Liability	"
"	Patient Compensation Fund (Amendment)	"
"	Periodic Payments	"
"	Peer Review -- Quality of Care Reform (Ambulatory Surgical Centers, Health Maintenance Organizations and Other In-House Patient Care Facilities)	"
"	Mandatory Insurance Coverage (Self-Insurance Allowed)	"
"	Standard of Care	"
"	JUA (Amendment)	1/1/77
Georgia		
S.B. 164	Peer Review -- Committee Immunity	4/18/75
"	Peer Review -- Discovery of Committee Files	"

State and Bill Number	Type of Legislation	Effective Date
Georgia (cont.)		
S.B. 377	Standby Insurance Pool	4/24/75
H.B. 1278	Peer Review -- Committee Immunity (Dentists)	7/01/76
"	Peer Review -- Quality of Care Reform (Dentists)	"
S.B. 464	Statute of Limitations	7/01/76
H.B. 1446	Ad Damnum Clause	9/06/76
Hawaii		
H.B. 1876	Standby JUA	5/30/75
H.B. 518	Peer Review -- Committee Immunity	6/02/75
"	Peer Review -- Discovery of Committee Files	"
H.B. 2700	Ad Damnum Clause	6/09/76
"	Attorney Fees	"
"	Advanced Payments	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Discovery of Patient Medical Files	"
"	Informed Consent	"
"	Mandatory Insurance Coverage	"
"	Patient's Compensation Fund	"
"	Peer Review -- Continuing Education	"
"	Peer Review -- Quality of Care Reform	"
"	Pre-Trial Panel (Mandatory)	"
"	Statute of Limitations	"
Idaho		
H.B. 163	Good Samaritan Law	3/18/75
"	Informed Consent	"
S.C.R. 117	Malpractice Study Authorized	3/20/75
S.B. 1229	Standby JUA	3/27/75
S.B. 1186	Attorney Fees	6/01/75
"	Collateral Source Rule	"
"	Limitation of Liability	"
"	Punitive Damages (Prohibited)	"
"	Standard of Care	"
H.B. 475	Statute of Limitations (Ionizing Radiation)	3/19/76
H.B. 645	Good Samaritan Law (Ambulance Attendants)	3/19/76
S.B. 1446	Standby JUA (Termination Date Extended)	3/24/76

State and Bill Number	Type of Legislation	Effective Date
Idaho (cont.)		
H.B. 474	Ad Damnum Clause	3/31/76
H.B. 478	Standard of Proof	3/31/76
"	Standard of Care	"
H.B. 348	Data Submitted to Commissioner Malpractice Claims Filed	7/01/76
H.B. 667	Peer Review -- Committee Immunity	7/01/76
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
H.B. 489	Pre-Trial Panel (Mandatory)	7/01/76
H.B. 473	Informed Consent (Basic Life Support)	7/01/76
"	Good Samaritan Law (Basic Life Support Personnel)	"
Illinois		
S.R. 36	Malpractice Study Authorized	3/24/75
H.B. 1968	Standby JUA	9/12/75
S.B. 1024	Hold Harmless Agreements	11/11/75
"	Malpractice Insurance Rates	"
"	Pre-Trial Panel (Mandatory)	"
"	Statute of Limitations	"
H.B. 3704	Good Samaritan Law (Emergency Medical Technicians)	10-01-76
Indiana		
H.B. 1460	Ad Damnum Clause	7/01/75
"	Advanced Payments	"
"	Attorney Fees	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Informed Consent	"
"	Limitation of Liability	"
"	Malpractice Study Authorized	"
"	Patient's Compensation Fund	"
"	Pre-Trial Panel (Mandatory)	"
"	Residual Malpractice Insurance Authority	"
"	Statute of Frauds/Agreements to Heal	"
"	Statute of Limitations	"
H.B. 1698	Peer Review -- Committee Immunity	"
"	Peer Review -- Quality of Care Reform	"
H.B. 1310	Amendment to Medical Malpractice Act	2/24/76

State and Bill Number	Type of Legislation	Effective Date
Iowa		
H.B. 803	Ad Damnum Clause	7/01/75
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Health Care Mutuals Authorized	"
"	Informed Consent	"
"	Peer Review -- Committee Immunity	"
"	Standby JUA	"
"	Statute of Limitations	"
S.J.R. 12	Malpractice Study Authorized	7/01/75
Kansas		
S.B. 353	Data Submitted to Commissioner on Malpractice Claims Filed (Informed Consent)	7/01/75
S.B. 278	Good Samaritan Law (Physician's Assistants)	7/01/75
S.B. 637	Data Submitted to Commissioner on Malpractice Claims Filed	4/20/76
S.B. 638	Ad Damnum Clause	7/01/76
S.B. 640	Attorney Fees	7/01/76
S.B. 639	Collateral Source Rule	7/01/76
S.B. 795	Good Samaritan Law	7/01/76
S.B. 658	Malpractice Study Authorized	7/01/76
S.B. 646	Malpractice Insurance Rates	7/01/76
"	Mandatory Insurance Coverage	"
"	Patient's Compensation Fund	"
H.B. 3155	Peer Review -- Committee Immunity	7/01/76
H.B. 2721	Peer Review -- Committee Immunity (Reporting Claims)	7/01/76
H.B. 2723	Peer Review -- Continuing Education	7/01/76
H.B. 2722	Peer Review -- Quality of Care Reform	7/01/76
H.B. 2724	Periodic Payments	7/01/76
S.B. 647	Pre-Trial Panel (Mandatory)	7/01/76
H.B. 2726	Statute of Limitations	7/01/76
Kentucky		
H.B. 712	Mandatory Insurance Coverage (University of Kentucky)	6/18/76
S.B. 249	Standby JUA	6/19/76
S.B. 248	Ad Damnum Clause	7/01/76
"	Advanced Payments	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"

State and Bill Number	Type of Legislation	Effective Date
Kentucky (cont.)		
S.B. 248	Informed Consent	7/01/76
"	Mandatory Insurance Coverage	"
"	Patient's Compensation Fund	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Discovery of Committee Files	"
"	Standby Insurance Pool/Plan	"
"	Statute of Frauds/Agreements to Heal	"
Louisiana		
S.C.R. 80	Malpractice Study Authorized	7/11/75
S.B. 46	Discovery of Patient Medical Files	9/12/75
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Discovery of Committee Files	"
S.B. 24	Good Samaritan Law	9/13/75
H.B. 17	Arbitration Agreements	9/15/75
H.B. 243	Definition of Insurance Redefined	9/15/75
H.B. 636	Informed Consent	9/15/75
H.B. 1006	Peer Review -- Quality of Care Reform	9/15/75
S.B. 396	Peer Review -- Committee Immunity (Dentists)	9/15/75
S.B. 476, S.B. 477	State Institutions Offer Malpractice Insurance	9/15/75
H.B. 1465	Ad Damnum Clause	10/03/75
"	Advanced Payments	"
"	Informed Consent	"
"	Limitation of Liability	"
"	Patient's Compensation Fund	"
"	Residual Malpractice Insurance Authority	"
"	Pre-Trial Panel	"
"	Statute of Frauds/Agreements to Heal	"
H.B. 637	Standard of Care	10/03/75
"	Standard of Proof	"
H.B. 638	Statute of Limitations	10/03/75
S.B. 801	Limitation of Liability (Health Care Providers Employed by the State)	7/02/76
H.B. 518	Data Submitted to Commissioner on Malpractice Claims Filed	10/01/76
H.B. 646	Patient's Compensation Fund (Amendment)	10/01/76

State and Bill Number	Type of Legislation	Effective Date
Louisiana (cont.)		
H.B. 646	Pre-Trial Panel (Amendment)	10/01/76
"	Residual Malpractice Insurance Authority (Amendment)	"
Maine		
S.B. 494	Malpractice Study Authorized	6/03/75
H.B. 1160	Standby JUA	6/11/75
H.B. 1252	Collateral Source Rule (Lien Prohibited)	9/30/75
H.B. 1648	Good Samaritan Law	9/30/75
L.D. 204	Peer Review -- Committee Immunity	9/30/75
L.D. 609	Peer Review -- Discovery of Committee Files	9/30/75
Maryland		
H.R. 184	Standards for Cancellation of Malpractice Coverage	4/04/75
S.B. 816	Health Care Mutuals Authorized	6/01/75
H.B. 617	Peer Review -- Quality of Care Reform (Amendment)	6/01/75
H.B. 875	Discovery of Patient Medical Files	7/01/75
S.B. 1072	JUA	7/01/75
H.B. 259	Peer Review -- Committee Immunity	7/01/75
S.B. 1055	Statute of Limitations	7/01/75
S.B. 72	Good Samaritan Law	5/17/76
H.B. 821	Good Samaritan Law	5/17/76
S.B. 476	Data Submitted to Commissioner on Malpractice Claims Filed	7/01/76
S.B. 436	Advanced Payments	7/01/76
"	Attorney Fees	"
"	Pre-Trial Panels	"
"	Statute of Limitations	"
H.B. 1035	Peer Review -- Committee Immunity	7/01/76
"	Peer Review -- Discovery of Committee Files	"
Massachusetts		
H.B. 6315	JUA	6/19/75
"	Malpractice Insurance Rates	"
"	Malpractice Study Authorized	"
"	Ad Damnum Clause	1/01/76
"	Pre-Trial Panel (Mandatory)	"
"	Statute of Limitations	"
S.B. 2017	Statute of Limitations (Minors)	6/19/75
H.B. 6223	Malpractice Study Amendment (Include HMO's)	6/30/75

State and Bill Number	Type of Legislation	Effective Date
Michigan		
S.B. 387	Data Submitted to Commissioner on Malpractice Claims Filed	5/12/75
H.R. 112	Malpractice Study Authorized	5/12/75
S.B. 507	Standby JUA	5/12/75
H.B. 4792	Peer Review -- Reporting Claims (Osteopaths)	6/06/75
H.B. 4973	Peer Review -- Reporting Claims (Doctors of Medicine)	6/07/75
H.B. 4858	Peer Review -- Committee Immunity	6/25/75
"	Peer Review -- Discovery of Committee Files	"
H.B. 4326	Good Samaritan Law	7/01/75
H.B. 4790	Discovery of Patient Medical Files (Solicitation Prohibited)	7/01/75
H.B. 4803	Arbitration Agreements	7/09/75
H.B. 4806	Arbitration Study Authorized	7/09/75
S.B. 818	Peer Review -- Committee Immunity (Podiatrists and Chiropodists)	7/09/75
"	Peer Review -- Discovery of Committee Files (Podiatrists and Chiropodists)	"
"	Peer Review -- Quality of Care Reform (Podiatrists and Chiropodists)	"
S.B. 227	Statute of Limitations	7/09/75
H.B. 6433	Peer Review -- Continuing Education	7/21/76
Minnesota		
H.B. 348,S.B. 1226	Standby JUA	4/14/76
S.B. 1906	Data Submitted to Commissioner on Malpractice Claims Filed	8/01/76
"	Peer Review -- Quality of Care Reform	"
Mississippi		
H.B. 614	Good Samaritan Law (Practical Nurse)	5/05/75
S.B. 2310	Malpractice Study Authorized	5/01/76
"	Standby JUA	"
S.B. 2197	Discovery of Patient Medical Files (Privilege Waived When Claim Filed)	7/01/76
S.B. 2428	Statute of Limitations	7/01/76

State and Bill Number	Type of Legislation	Effective Date
Missouri		
S.R. 67	Malpractice Study Authorized	2/27/75
S.B. 458	Health Care Mutuals Authorized	6/26/75
H.B. 479	Peer Review -- Committee Immunity (Chiropractors)	9/29/75
H.B. 1307	Ad Damnum Clause	8/13/76
H.B. 1308	Data Submitted to Commissioner on Malpractice Claims Filed	8/13/76
H.B. 1309	Standby JUA	8/13/76
S.B. 470	Statute of Limitations	8/13/76
S.B. 472	Peer Review -- Qualtiy of Care Reform	8/13/76
S.B. 471	Notice of Claim Prior to Filing Action	1/01/77
"	Pre-Trial Panel	"
Montana		
H.B. 72	Good Samaritan Law (Emergency Technicians)	7/01/75
S.B. 190	Peer review -- Committee Immunity	7/01/75
Nebraska		
L.R. 64	Malpractice Study Authorized	6/01/75
L.B. 418	Good Samaritan Law (Ambulance Attendant)	7/01/75
L.B. 560	Advanced Payments	8/23/75
L.B. 140	Limitation of Liability	8/23/75
L.B. 917	Standby Insurance Pool/Plan	4/06/76
L.B. 434	Ad Damnum Clause	7/10/76
"	Advanced Payments	"
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Informed Consent	"
"	Limitation of Liability	"
"	Mandatory Insurance Coverage	"
"	Patient's Compensation Fund	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
"	Pre-Trial Panel	"
"	Residual Malpractice Insurance Authority	"
"	Standard of Care	"
"	Standard of Proof	"

State and Bill Number	Type of Legislation	Effective Date
Nebraska (cont.)		
L.B. 434	Statute of Frauds/Agreements to Heal	7/10/76
"	Statute of Limitations	"
Nevada		
S.B. 403	Advanced Payments	4/30/75
S.B. 402	Good Samaritan Law	4/30/75
S.B. 408	Informed Consent	4/30/75
S.B. 432	Peer Review -- Committee Immunity	4/30/75
"	Peer Review -- Discovery of Committee Files (Allowed)	4/30/75
"	Peer Review -- Quality of Care Reform	"
"	Standard of Care	"
S.B. 409	Pre-Trial Panel (Mandatory)	4/30/75
S.B. 401	Commissioner's Powers for JUA Regulation Expanded	4/30/75
S.B. 400	Standby JUA	4/30/75
S.B. 405	Standard of Proof	4/30/75
S.B. 406	Statute of Limitations	4/30/75
S.C.R. 21	Malpractice Study Authorized	5/02/75
S.B. 610	Data Submitted to Commissioner on Malpractice Claims Filed	7/01/75
New Hampshire		
H.B. 77	Good Samaritan Law (Nurses)	7/01/75
S.B. 92	Standby Insurance Pool/Standby JUA	8/02/75
"	Malpractice Study Authorized	"
H.B. 903	Peer Review -- Committee Immunity	8/06/75
New Jersey		
S.C.R. 3001	Malpractice Study Authorized	5/05/75
A. 1552	Professional Liability Reinsurance Exchange	1/30/76
New Mexico		
H.J.M. 28	Malpractice Study Authorized	3/22/75
S.B. 373	Peer Review -- Quality of Care Reform (Osteopaths)	6/20/75
"	Standard of Care (Osteopaths)	"
H.B. 29	Ad Damnum Clause	2/27/76
"	Advanced Payments	"

State and Bill Number	Type of Legislation	Effective Date
New Mexico (cont.)		
H.B. 29	Limitation of Liability	2/27/76
"	Patient's Compensation Fund	"
"	Pre-Trial Panel (Mandatory)	"
"	Punitive Damages (Allowed)	"
"	Standard of Proof	"
"	Statute of Limitations	"
H.B. 30	Peer Review -- Committee Immunity	3/01/76
"	Peer Review -- Discovery of Committee Files	"
H.B. 32	Standby JUA	3/01/76
New York		
S. 6449, A. 8433	Collateral Source Rule	7/01/75
" "	Data Submitted to Commissioner on Malpractice Claims Filed	"
" "	Informed Consent	"
" "	Malpractice Insurance Rates (Exemption from Competitive Pricing Law)	"
" "	Pre-Trial Panel (Mandatory)	"
" "	Standby JUA	5/21/75
" "	Statute of Limitations	"
" "	Peer Review -- Committee Immunity	9/01/75
" "	Peer Review -- Discovery of Committee Files	"
" "	Peer Review -- Quality of Care Reform	"
A. 8547	Informed Consent (Amendment	7/01/75
S. 6900, A. 8782	JUA (Incidental Liability Coverage Authorized for Hospitals)	7/25/75
S. 7262-A	Good Samaritan Law (Physician's Assistants)	6/08/76
S. 3988-A	Peer Review -- Committee Immunity (Chiropractors)	6/21/76
"	Peer Review -- Discovery of Committee Files (Chiropractors)	"
North Carolina		
H.B. 74	Health Care Liability Reinsurance Exchange	5/28/75
H.B. 567	Malpractice Study Authorized	6/16/75
S.B. 901	Malpractice Study Amendment	6/26/75
S.B. 959	Residual Malpractice Insurance Authority (Excess Liability)	5/13/76
H.B. 1293	Ad Damnum Clause	7/01/76
H.B. 1293	Data Submitted to Commissioner on Malpractice Claims Filed	"

State and Bill Number	Type of Legislation	Effective Date
North Carolina (cont.)		
H.B. 1293	Good Samaritan Law	7/01/76
"	Informed Consent	"
"	Standard of Care	"
"	Statute of Frauds	"
"	Statute of Limitations	"
North Dakota		
H.B. 1614	Health Care Mutuals Authcrized	7/01/75
S.B. 2349	Peer Review -- Discovery of Committee Files	7/01/75
S.B. 2348	Statute of Limitations	7/01/75
Ohio		
S.B. 263	State Institutions Authorized to Purchase Malpractice Insurance	7/03/75
H.B. 682	Ad Damnum Clause	7/28/75
"	Arbitration Agreements	"
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Informed Consent	"
"	JUA	"
"	Limitation of Liability	"
"	Malpractice Study Authorized	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
"	Standard of Care	"
"	Standard of Proof	"
"	Statute of Frauds/Agreements to Heal	"
"	Statute of Limitations	"
H.B. 85	Limitation of Liability (Child Abuse Reports)	11/28/75
Oklahoma		
H.B. 1277	Peer Review -- Committee Immunity	4/18/75
S.B. 296	Limitation of Liability (Doctor's report to Department of Public Safety)	5/19/75
H.B. 1537	Limitation of Liability (Minors)	5/29/75
S.B. 622	Data Submitted to Commissioner on Malpractice Claims Filed	4/08/76

State and Bill Number	Type of Legislation	Effective Date
Oklahoma (cont.)		
S.B. 622	Discovery of Patient Medical Files	4/08/76
"	Residual Malpractice Insurance Authority	"
"	Standard of Care	"
"	Statute of Limitations	"
Oregon		
H.B. 2331	Peer Review -- Committee Immunity	7/08/75
H.B. 2647	Attorney Fees	9/13/75
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Limitation of Liability	"
"	Patient's Compensation Fund	"
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
"	Punitive Damages (Allowed)	"
"	Standard of Care	"
"	Statute of Limitations	
Pennsylvania		
H.B. 1367	Advanced Payments	1/01/76
"	Arbitration Agreements (Mandatory)	"
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Informed Consent	"
"	JUA	"
"	Limitation of Liability	"
"	Malpractice Study Authorized	"
"	Patient's Compensation Fund	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Quality of Care Reform	"
"	Punitive Damages (Allowed)	"
"	Statute of Frauds/Agreements to Heal	"
Puerto Rico		
S.B. 1788	JUA	7/01/76
"	Mandatory Insurance Coverage	"
"	Patient's Compensation Fund	"
"	Pre-Trial Panel	"
"	Statute of Limitations	"

State and Bill Number	Type of Legislation	Effective Date
Rhode Island		
Sub. A		
75-H-6329	Malpractice Study Authorized	5/15/75
Emerg. Reg. 21	JUA	7/01/75
H. 7017	Standby JUA	1/09/76
S. 2816	JUA	5/14/76
H. 7796	Ad Damnum Clause	9/01/76
"	Collateral Source Rule	"
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Informed Consent	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Continuing Education	"
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
"	Pre-Trial Panel (Mandatory)	"
"	Standard of Proof	"
"	Statute of Limitations	"
South Carolina		
S.B. 288	Standby JUA	5/07/75
H.B. 2866	Malpractice Study Authorized	6/17/75
S.B. 832	Data Submitted to Commissioner on Malpractice Claims Filed	6/29/76
S.B. 839	Patient's Compensation Fund	6/29/76
S.B. 835	Standby JUA (Amendment)	7/19/76
H.B. 3878	Peer Review -- Committee Immunity	5/25/76
"	Peer Review -- Quality of Care Reform	"
South Dakota		
S.C.R. 13	Malpractice Study Authorized	3/04/75
S.B. 258	Peer Review -- Committee Immunity	7/01/75
H.B. 827	Statute of Limitations	7/01/75
H.B. 525	Arbitration Agreements	2/20/76
H.B. 527	Data Submitted to Commissioner on Malpractice Claims Filed	7/01/76
H.B. 619	Good Samaritan Law (Physician's Assistants)	7/01/76
H.B. 637	Health Care Mutuals Authorized	7/01/76
S.B. 142	Limitation of Liability	7/01/76
Tennessee		
H.J.R. 47	Malpractice Study Authorized	3/12/75

State and Bill Number	Type of Legislation	Effective Date
Tennessee (cont.)		
S.B. 547	Peer Review -- Committee Immunity	5/08/75
"	Peer Review -- Discovery of Committee Files	"
S.B. 576	Peer Review -- Committee Immunity (Chiropractors)	5/20/75
H.B. 1013	Standby JUA	6/06/75
H.B. 1035	Ad Damnum Clause	7/01/75
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Informed Consent	"
"	Pre-Trial Panel (Mandatory)	"
"	Standard of Care	"
"	Standard of Proof	"
"	Statute of Limitations	"
H.B. 1710	Pre-Trial Panel (Amendment)	3/29/76
H.B. 1804	Mandatory Insurance Coverage (Medical Schools)	3/29/76
S.B. 1881	Standby JUA (Amendment)	5/08/76
H.B. 2295, S.B. 2227	Health Care Mutuals Authorized	6/08/76
Texas		
S.B. 717	Peer Review -- Committee Immunity (Chiropractors)	5/22/75
S.B. 704	State Pays and Defends Malpractice Claims Against its Employees	5/27/75
S.R. 234	Malpractice Study Authorized	5/30/75
S.B. 466	Data Submitted to Commissioner on Malpractice Claims Filed	6/03/75
"	Malpractice Insurance Rates	"
"	Statute of Limitations	"
S.B. 491	JUA	6/03/75
"	Malpractice Study Authorized	"
S.B. 453	Advanced Payments	6/19/75
Utah		
H.B. 35	Ad Damnum Clause	4/02/76
"	Data Submitted to Commissioner on Malpractice Claims Filed	"
"	Informed Consent	"
"	Medical Consent	"
"	Notice of Claim Prior to Filing Action	"
"	Standard of Proof	"
"	Standby Insurance Pool/Plan	"
"	Statute of Frauds/Agreements to Heal	"
"	Statute of Limitations	"

State and Bill Number	Type of Legislation	Effective Date
Vermont		
S.J.R. 43	Malpractice Study Authorized	4/07/76
S. 171	Informed Consent	4/17/76
"	Standard of Care	"
"	Standard of Proof	"
"	Statute of Frauds/Agreements to Heal	"
S. 169	Arbitration Agreements	7/01/76
S. 170	Peer Review -- Committee Immunity	7/01/76
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"
Virginia		
H.J.R. 174	Malpractice Study Authorized	2/13/75
H.B. 416	Limitation of Liability (Child Abuse Reports)	6/01/75
S.B. 615	Peer Review -- Committee Immunity	6/01/75
S. 122	Standby JUA	3/26/76
H.B. 803	Limitation of Liability (Charitable Institutions)	6/13/76
S.J.R. 80	Malpractice Study Authorized	6/13/76
S.B. 115	Arbitration Agreements	6/15/76
"	Limitation of Liability	"
"	Notice of Claim Prior to Filing Action	"
"	Peer Review -- Committee Immunity	"
"	Peer Review -- Discovery of Committee Files	"
"	Pre-Trial Panel (Voluntary)	"
Washington		
H.B. 788	Peer Review -- Committee Immunity	9/02/75
"	Peer Review -- Quality of Care Reform	"
H.B. 48	Good Samaritan Law	9/08/75
S.B. 2058	Peer Review -- Discovery of	9/08/75
"	Standard of Care	"
H.B. 246	Standard of Proof	9/08/75
S.B. 3033	Health Care Mutuals Authorized	9/01/75
H.B. 1470	Ad Damnum Clause	6/25/76
"	Advanced Payments	"
"	Attorney Fees	"
"	Collateral Source Rule	"
"	Informed Consent	"
"	Peer Review -- Committee Immunity	"

State and Bill Number	Type of Legislation	Effective Date
Washington (cont.)		
H.B. 1470	Periodic Payments	6/25/76
"	Standard of Care	"
"	Standard of Proof	"
West Virginia		
S.B. 510	Peer Review -- Committee Immunity	6/06/75
H.B. 1573	Advanced Payments	6/10/76
Wisconsin		
A.B. 53	Arbitration Agreements	2/15/75
A.B. 58	Standby Insurance Pool	3/15/75
A.R. 33	Malpractice Study Authorized	6/27/75
A.B. 725	Patient's Compensation Fund	7/01/75
"	Ad Damnum Clause	"
"	Attorney Fees	"
"	JUA	"
"	Limitation of Liability	"
"	Malpractice Study Authorized	"
"	Peer Review -- Quality of Care Reform	"
"	Periodic Payments	"
"	Pre-Trial Panel (Voluntary)	"
"	Peer Review -- Continuing Education	1/01/75
A.B. 960	Patient's Compensation Fund (Amendment)	7/24/75
A.B. 59	Data Submitted to Commissioner on Malpractice Claims Filed	8/23/75
S.B. 597	Amendments to Recent Malpractice Legislation	10/02/75
A.B. 55	Limitation of Liability (Handling Blood)	10/04/75
A.B. 57	Limitation of Liability (Tissue Transplants)	10/04/75
A.B. 1351	Peer Review -- Committee Immunity	4/03/76
"	Peer Review -- Discovery of Committee Files	"
S.B. 179	Advanced Payments	6/13/76
A.B. 1067	Peer Review -- Quality of Care Reform	6/15/76
Wyoming		
H.B. 361	Good Samaritan Law (In Hospital)	3/05/75
H.B. 11A	Statute of Limitations	5/28/76

State and Bill Number	Type of Legislation	Effective Date
Wyoming (cont.)		
S.B. 31	Ad Damnum Clause	5/28/76
H.B. 17	Data Reported to Commissioner on Malpractice Claims Filed	5/28/76
S.B. 5	Peer Review -- Committee Immunity	5/28/76
"	Peer Review -- Discovery of Committee Files	"
"	Peer Review -- Quality of Care Reform	"

GLOSSARY

Ad Damnum Clause - clause in plaintiff's complaint requesting specific monetary damages. States which have enacted this type of malpractice legislation have eliminated the ad damnum clause in malpractice actions.

Advanced Payments - laws declaring that any advanced payment by the defendant may not be construed as an admission of liability for injuries or damages suffered by the plaintiff. Some states may restrict the admissability of evidence relating to advanced payments until after judgement is rendered.

Arbitration Agreements - laws governing written agreements, entered into voluntarily, which provide for submission of medical malpractice claims to an impartial panel for final determination. Such agreements are binding on the parties, enforceable at law under general or medical malpractice statutes and a substitute for a court trial. Arbitration agreements should not be confused with pre-trial screening panels which are usually mandatory and nonbinding.

Attorney Fees - laws which place limitations on the amount an attorney can charge as a fee in a malpractice case.

Collateral Source Rule - laws reducing an award of damages in a malpractice case by other collateral recovery. Other "collateral recovery" may include proceeds from the plaintiff's own insurance policies, veteran's benefits, etc.

Data Submitted to Commissioner on Malpractice Claims Filed - laws requiring insurance carriers, or in some cases doctors or medical review screening panels, to submit information relating to pending malpractice actions to the state insurance commissioner or other designated authority.

Discovery of Patient Medical Files - laws authorizing the discovery of a patient's medical records from the files of a hospital, a doctor's office or an insurance company.

Good Samaritan Law - laws which remove liability from persons providing medical treatment in emergency situations. Good Samaritan Laws can apply to designated categories of persons - such as physicians, nurses, etc. - or they can apply to designated places of treatment - such as in hospitals, emergency rooms, etc. - or both.

Health Care Liability Reinsurance Exchange - See Reinsurance Exchange.

Health Care Mutuals Authorized - laws providing for the establishment and operation of mutual insurance organizations which may provide medical malpractice insurance coverage for participating members. Physicians, surgeons, osteopaths, hospitals and nurses are examples of the types of health care professionals who may be allowed to form mutual companies under this type of legislation.

Hold Harmless Agreements - written waivers signed by patients prior to medical treatment which declare that no action will be brought against the health care provider as a result of such treatment. States enacting this type of legislation prohibit hold harmless contracts.

Informed Consent - laws restricting causes of action based on the failure to disclose pertinent information to the patient regarding the nature and purpose of medical procedures or the risks associated with such procedures. In some states, a presumption may be created that informed consent was given if certain prescribed steps are followed; in other states an absolute prohibition may be established if certain conditions are met.

JUA - laws establishing a "Joint Underwriting Association" composed of specified insurance carriers. The JUA is an independent organization, temporary in nature, which may offer liability policies for health care providers who cannot obtain coverage in the private insurance market. It functions under a plan of operation approved by the insurance commissioner and is subject to the state insurance code with respect to rates, policy forms, etc. Underwriting profits and losses of the JUA are shared ratably by participating members.

Limitation of Liability - laws placing a dollar limit on the amount of damages a plaintiff may recover in a malpractice suit. Limitation of liability laws may also absolve health care providers from liability which may arise during the course of certain types of activities - such as drawing blood. This latter definition should not be confused with Good Samaritan Laws which limit the liability of certain persons during emergency treatment.

Malpractice Insurance Rates - laws setting limitations on rates charged by malpractice carriers.

Malpractice Study Authorized - laws directing a legislative study commission or other authorized body to gather information on the medical malpractice problem and report back to the state legislature within a specified period of time.

Mandatory Insurance Coverage - laws mandating proof of financial responsibility through the purchase of malpractice liability insurance or the depositing of a specified sum with the commissioner of insurance. This phrase also describes those state laws requiring insurers to notify the commissioner when a professional liability policy is cancelled or not renewed.

Medical Consent - laws which authorize certain persons to consent to surgical or medical treatment for a patient. No person who consents for another in good faith is subject to liability.

Notice of Claim Prior to Filing Action - laws prohibiting commencement of a malpractice action unless the plaintiff notifies the defendant of his/her intention to file suit prior to the actual filing of the action.

Patient's Compensation Fund - fund used to pay malpractice claims which are in excess of the financial responsibility limits established by law. Contributions to the fund can be assessed in a variety of ways, the most common being a surcharge placed on the malpractice premiums of all professional liability policyholders in the state. The fund is administered by a trustee - which may be a JUA - and usually has limitations on the amount of reserves it may accumulate. A Patient's Compensation Fund should not be confused with a Stabilization Reserve Fund, the latter being a back-up fund for a state's JUA.

Peer Review - Committee Immunity - laws which absolve physicians and other health care providers from liability arising out of any reasonable act or proceeding performed in the course of carrying out their responsibilities as a member of a peer review committee.

Peer Review - Continuing Education - laws requiring participation in a medical education program after graduation from medical school as prerequisite for renewal of license to practice medicine.

Peer Review - Discovery of Committee Files - laws which place restrictions on the use or discovery of peer review testimony or records in any civil action against a health care provider.

Peer Review - Quality of Care Reform - legislation establishing a formal apparatus for supervising the quality of health care offered by hospitals, doctors, and other health care professionals.

Periodic Payments - laws which authorize the entry of judgements against health care providers in such a manner that the payment of future damages is made through periodic installments rather than one lump-sum amount. This type of legislation attempts to eliminate the potential windfall from a lump-sum recovery which results when an injured plaintiff receives a lump-sum judgement but dies shortly thereafter.

Pre-Trial Panels - laws establishing legal framework for submitting malpractice claims to a medical-legal panel prior to trial. Decisions of the panel can be binding or nonbinding; optional or mandatory; and either admissable or inadmissable at a later trial. Pre-trial panel laws usually set guidelines for the composition of the panel, the type of evidence it can hear, and the qualifications of its members. In many respects pre-trial panel laws are very similar to arbitration laws.

Professional Liability Reinsurance Exchange - See Reinsurance Exchange.

Punitive Damages - laws which either allow or prohibit punitive damages in medical malpractice cases.

Reinsurance Exchange - plan for pooling malpractice risks. A reinsurance exchange will accept a standard percentage of reinsurance - usually 100% - from member carriers. In return for this risk assumption no insurance agent can refuse to write a professional liability policy for a health care provider. A reinsurance exchange is very similar to a JUA: both are mandatory pooling arrangements which guarantee liability coverage for health care providers. The principal difference between the two is that a JUA may underwrite its own risks while a reinsurance exchange may only reinsure the risks of others, even though the reinsurance percentage may be 100%.

Residual Malpractice Insurance Authority - enabling legislation authorizing the department of insurance to underwrite professional liability policies. The commissioner must appoint a risk manager to conduct the business affairs of the Authority. Initial capitalization requirements are met through general tax revenues and any underwriting losses must likewise be funded by a state's tax receipts. Unlike JUA's or a reinsurance exchange, a residual malpractice insurance authority is not a pooling arrangement. It operates on the same basis as any other private insurance carrier. Like the JUA's and reinsurance exchanges, however, its primary purpose is to provide professional liability insurance to health care providers who cannot obtain coverage in the private market.

Standard of Care - laws defining medical malpractice. The definition of medical malpractice is most often found in peer review statutes, but it can also be used to describe what constitutes malpractice for the purpose of a patient's cause of action. Standard of care laws may also address themselves to the "locality rule" problem; that is, should the health care provider be judged by the standards of the local community, or should national standards of competence be applied in medical malpractice litigation? Some states have made this choice through legislation; others leave such a decision to the courts.

Standard of Proof - laws laying down the burden of proof in malpractice litigation. This term is also used to describe "Res Ipsa Loquitur," a doctrine in English common law which says that a certain result cannot be obtained unless there is negligence on the part of one of the parties. Thus, "the thing speaks for itself." The term Standard of Proof may also represent legislation governing the qualifications and procedures for expert testimony in malpractice litigation.

Standby Insurance Pool/Plan - laws requiring casualty insurers to draft agreements which equitably apportion casualty insurance risks among themselves. Such agreements are subject to the approval of the commissioner of insurance and are mandatory once the commissioner determines, in writing, that the public interest necessitates their drafting. The purpose of such agreements is to provide casualty insurance coverage to those applicants who are

unable to procure coverage in the private market. This type of availability plan is distinguishable from JUA's, reinsurance exchanges and residual malpractice insurance authorities since it places the responsibility of drafting the pooling agreement in the hands of the participants, i.e., insurance carriers.

Standby JUA - type of "Joint Underwriting Association" which goes into effect only after the commissioner of insurance finds that medical malpractice insurance is not substantially available through private insurers. See JUA.

Statute of Frauds/Agreements to Heal - laws prohibiting malpractice actions based on a contract theory unless there is written evidence of a contract. Thus, there can be no warranty of result unless the health care provider signs a document setting forth the terms of the warranty.

Statute of Limitations - laws cutting off a cause of action based on a claim of medical malpractice after the expiration of a specified time period. The statute can begin to run from either the date of occurrence or the date of discovery. Special rules may also be created to govern the situation where medical misconduct is alleged in the case of a minor.

CONSTITUTIONAL CHALLENGES TO RECENT MEDICAL MALPRACTICE LEGISLATION*

Arizona

Arizona's "Joint Underwriting Plan" (JUP) has been challenged in Nathan V. Arizona Joint Underwriting Plan, Cause No. 160814 (Arizona Superior Court for Pima County, filed April 27, 1976). An order to show cause was granted by the court and a hearing set for June 3, 1976, but no final determination has been made on the constitutionality of the JUA (H.B. 2001).

Florida

The Florida Supreme Court recently held in Carter v. Sparkman, Case No. 48,039 (May 5, 1976) that the mandatory pre-trial panel system established under the state's 1975 medical malpractice legislation (H.B. 1267) was within constitutional limits. The court stated that "even though the pre-litigation burden cast upon the claimant reaches the outer limits of constitutional tolerance, we do not deem it sufficient to void the medical malpractice law."

Illinois

The Illinois Supreme Court handed down the first state supreme court decision on recent malpractice legislation in Wright v. Central DuPage Hospital Ass'n, 347 N.E. 2d. 736 (May 14, 1976). The court struck down most of the reforms in the Illinois Medical Malpractice Act, Pub. Act 79-960, as violating the Illinois Constitution. In particular, it found that pretrial panels under the Act vested "essentially judicial functions in nonjudicial personnel" and placed an impermissible restriction on the right of trial by jury. A $500,000 limit on recoveries in malpractice cases was also declared unconstitutional because it violated an Illinois constitutional prohibition against special legislation. A third section of the Act dealing with the cancellation and rates of malpractice policies was declared unconstitutional for the same reason: it created special legislation in violation of section 13 of article IV of the Illinois Constitution.

Indiana

Indiana's medical malpractice legislation, H.B. 1460, has been challenged in Hewitt v. Gaddy, No. 56-75-1557 (Superior Court for Marion County). The plaintiff filed a medical malpractice suit ignoring the provisions of Indiana's new law. No ruling has been made in the case but an opinion is expected sometime this fall.

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*This summary was prepared by the National Association of Insurance Commissioners and is contained in their report entitled NAIC Malpractice Claims. Reprinted by permission.

New York

A New York Supreme Court judge recently upheld New York's pretrial panel law (S.6449, A.8433) in Halpern v. Gozan, 381 N.Y.S. 2d 744 (1976). The court examined in detail the history surrounding the law and found that "some procedure to expedite the disposition of malpractice cases" had to be found. The court specifically stated that pretrial panels in malpractice cases did not "invade the jury province contrary to constitutional mandates."

North Carolina

The North Carolina Supreme Court has upheld a lower court ruling in State Farm v. Ingram, No. 91-Wake (Spring Term 1976), thereby invalidating the North Carolina Health Care Liability Reinsurance Exchange Act, ch. 427 [1975] N.C. Sess. Laws. The Act was found to violate the law of the land clause of the North Carolina Constitution and the due process clause of the Fourteenth Amendment to the U.S. Constitution because it required the writing of malpractice insurance "by companies who have never engaged, and do not want to engage and are not equipped to engage, in the business at all." The court specifically refused to decide whether "the State may constitutionally require a company voluntarily engaging in the health care liability insurance business to insure all licensed providers of health care services against liability for their negligence in their practice", however.

Ohio

An Ohio Court of Common Pleas has struck down the collateral source provision in Ohio's recently enacted medical malpractice law, H.B. 162 [1975] Ohio Sess. Laws 347. The court in Graley v. Satayatham, 343 N.E. 2d 832 (1976), found that the limitation imposed by the Ohio collateral source provision violated the equal protection clauses of the United States and Ohio constitutions because the rule treats claimants in medical malpractice suits differently from claimants in other personal injury suits. The court left standing, however, the statute's $200,000 limit on liability for medical malpractice damages not involving death.

Tennessee

Tennessee's medical malpractice review board, or pretrial panel, has been challenged in Arnold v. Tennessee, No. 2-396-75 (Chancery Court for Davidson County, filed Sept. 18, 1975). Plaintiff has alleged various grounds for holding the pretrial panels unconstitutional but no decision has been handed down thus far.

ADDITIONAL DATA

CHART VII

AETNA LIFE AND CASUALTY
PHYSICIANS & SURGEONS - TOTAL LIMITS
IN MONTANA

Policy Year Earned Premium	Losses	Evaluated At: 27 Months	39 Months	51 Months	63 Months	75 Months	Number of Claims: Closed	Open
1965	Paid	320	47 484	52 173	120 076	128 548	2	?
	Case Reserve	29 730	5 000	31 851	23 226	9 413		
50 573	Actuarial Res.	35 454	52 596	26 298	9 103	0		
	Total Incurred	65 504	105 080	110 322	152 405	137 961		
1966	Paid	85	11 150	14 768	37 269	47 204	5	8
	Case Reserve	25 665	31 095	94 233	81 042	68 770		
51 977	Actuarial Res.	100 836	52 496	21 830	5 509	0		
	Total Incurred	126 586	94 741	130 831	123 820	115 974		
1967	Paid	486	3 547	14 891	15 607	18 086	1	?
	Case Reserve	9 518	23 455	14 412	45 234	66 007		
54 561	Actuarial Res.	110 759	34 372	11 730	7 748	0		
	Total Incurred	120 763	61 374	41 033	68 589	84 093		
1968	Paid	0	5 855	5 969	10 404	13 266	3	?
	Case Reserve	8 510	500	13 886	11 432	40 570		
85 278	Actuarial Res.	115 134	37 351	25 326	22 705	0		
	Total Incurred	123 644	43 706	45 181	34 541	53 836		
1969	Paid	0	1 871	5 620	5 644	8 916	2	1
	Case Reserve	15 700	27 893	10 727	15 176	7 847		
137 835	Actuarial Res.	77 877	44 658	28 117	12 818	6 064		
	Total Incurred	93 577	74 422	44 464	33 638	22 827		
1970	Paid	994	1 025	2 115	5 337	11 991	0	6
	Case Reserve	5 000	13 468	124 577	154 350	121 877		
300 346	Actuarial Res.	117 727	79 291	48 355	23 128	11 113		
	Total Incurred	123 721	93 784	175 047	182 815	144 981		
1971	Paid	22 555	74 275	80 525	120 267		6	3
	Case Reserve	47 512	9 205	65 823	19 024			
386 890	Actuarial Res.	199 165	130 382	75 058	31 338			
	Total Incurred	269 232	213 862	221 406	170 629			
1972	Paid	47 125	113 916	183 406			8	8
	Case Reserve	126 079	108 830	104 448				
377 898	Actuarial Res.	231 275	171 567	61 975				
	Total Incurred	404 479	394 313	349 829				
1973	Paid	2 870	16 427				5	?
	Case Reserve	72 081	50 000					
329 793	Actuarial Res.	291 537	140 822					
	Total Incurred	366 488	207 249					
1974	Paid	33 683					6	6
	Case Reserve	50 615						
481 .69	Actuarial Res.	332 482						
	Total Incurred	416 780						

Source: Mr. Lester Senger, Aetna Life and Casualty

CHART VIII

LIFE & CASUALTY

151 Farmington Avenue
Hartford, Connecticut 06115

Lester F. Senger
Vice President, Industry Affairs
Casualty & Surety Division

September 22, 1976

RECEIVED
SEP 27 1976
MONTANA LEGISLATIVE COUNCIL

Mr. Dennis M. Taylor, Researcher
Montana Legislative Council
State Capitol
Helena, Montana 59601

SUBJECT: SELECT COMMITTEE ON MEDICAL MALPRACTICE

Dear Mr. Taylor:

According to my notes when I appeared before the Montana Legislative Council, I was asked to try to develop certain additional information.

One of the things I was asked to do was to try to provide some calendar year data for Montana which would be comparable to the countrywide data which we normally furnish to the Montana Medical Society. In response to that request, our actuaries have prepared the following data:

Calendar Year	Earned Premium	Underwriting Profit	Investment Income Rate of Returns	Unearned Premium and Loss Reserves	Combined Profit
		(All data in thousand's of dollars)			
1973	571.0	-126.6	4.00%	62.8	- 63.8
1974	473.7	-274.0	3.31	46.7	- 227.3
1975	1,334.5	+ 26.7	5.20	170.3	+ 197.0
Total:	2,739.2	-373.9		279.8	- 94.1

When using this information, you should be careful to recognize:

(1) The Ætna does not make investments on a state by state basis. Therefore, it is difficult for us to be totally accurate in estimating the rate of return or the actual income resulting from investment income related to Montana developed reserves. However, the actuaries have done the most accurate estimate possible but with the understanding that it be fully recognized that this is not the type of record we normally develop nor would we expect to develop it in the future.

CHART XI

REPORTED CLAIMS AMOUNTS,
UNREPORTED CLAIMS AMOUNTS, AND EXPENSES (*)
AETNA LIFE AND CASUALTY IN MONTANA

Effective Periods	Earned Premium	Reported Claims Paid	Reported Claims Unpaid	Unreported Claims Amt	Unallocated Loss Adjustment Expens	Total
1/1/73-12/31/73	$ 286,064	$10,522	$50,000	$ 75,521	$13,468	$149,51
1/1/74-12/31/74	472,666	33,511	50,616	222,153	30,015	336,29
1/1/75-12/31/75	1,161,288	16,752	100,487	603,870	65,621	786,73

Source: Aetna Letter to MMA, June 30, 1976.

* Unreported Claims Amount is IBNR; allocated loss adjustment expense is included in reported claims and IBNR; unallocated loss adjustment expense as a percentage of incurred loss is: 9.9% in 1973, 9.8% in 1974, 9.1% in 1975. The number of paid and unpaid reported claims in the periods are 12 in 1973, 35 in 1974, and ` in 1975. Evaluation date of 4/1/76.

CHART X

ST. PAUL FIRE AND MARINE INSURANCE COMPANY
PHYSICIANS AND SURGEONS LOSS AND LOSS EXPENSE EXPERIENCE
STATE OF MONTANA

Calendar Year	Number of Paid Claims	Paid Loss	Paid Loss Expense	Claims Incurred	Claims Closed With No Payment	Incurred Loss and Loss Expense
1968	3	$19,244	$23,304	6	5	$278,048
1969	4	33,536	18,046	9	0	159,207
1970	3	83,492	42,469	10	10	-7,914
1971	2	36,200	17,925	9	7	8,375
1972	5	73,243	18,047	10	4	-27,960
1973	0	0	17,051	17	5	161,051
1974	3	4,254	20,377	12	8	150,631
1975	5	69,470	15,330	21	16	162,800

At least 14 of the 25 paid claims were settled out of court.

Source: Enclosure, letter from Jon Roeder, Specialist, Professional Liability Risk, St. Paul Fire & Marine Insurance Company, 17 June 1976.

DISTRIBUTION OF TOTAL MALPRACTICE INSURANCE PREMIUM INCOME, INCURRED LOSSES, CLOSED CLAIMS AND CLAIMS FILES OPENED BY STATE, 1970

State	Percentage of U.S. Total			
	Premium Income	Incurred[1] Losses	Closed Claims	Claims Files Opened
Alabama	.9	.6	.7	.7
Alaska	*	*	*	*
Arizona	1.2	1.3	1.5	1.4
Arkansas	.5	.4	.5	.5
California	23.1	22.2	18.9	24.6
Colorado	1.5	1.2	1.7	1.6
Connecticut	1.7	.6	1.2	1.1
Delaware	*	*	*	*
District of Columbia	.6	1.3	1.1	.4
Florida	2.4	1.7	3.2	3.2
Georgia	1.1	1.5	1.2	.5
Hawaii	.2	.2	.2	.1
Idaho	.2	*	.2	.3
Illinois	4.5	3.8	6.5	6.3
Indiana	1.8	1.3	1.8	1.7
Iowa	1.2	.9	1.0	.8
Kansas	.7	.5	.9	.8
Kentucky	1.1	.5	.9	.8
Louisiana	1.2	.8	1.3	1.0
Maine	.3	.1	.2	.3
Maryland	1.2	2.8	2.0	1.5
Massachusetts	2.1	1.8	1.9	1.3
Michigan	5.4	3.6	4.5	4.7
Minnesota	1.5	1.4	2.5	1.3
Mississippi	.3	.2	.5	.2
Missouri	1.8	.8	1.9	1.8
Montana	.4	.1	.4	.4
Nebraska	.5	.6	.6	.4
Nevada	.4	.2	.4	.5
New Hampshire	.2	.1	.4	.4
New Jersey	5.0	7.9	4.9	5.3
New Mexico	.4	.6	.4	.3
New York	11.8	20.4	12.1	12.8
North Carolina	.6	.4	.7	.7
North Dakota	.1	.2	.2	.1
Ohio	4.9	3.6	3.9	3.8
Oklahoma	.4	1.0	.9	.2
Oregon	.6	.6	1.0	.6
Pennsylvania	4.4	3.8	5.6	6.0
Puerto Rico	.1	*	*	*
Rhode Island	.2	.1	.2	.2
South Carolina	.3	.1	.4	.1
South Dakota	.2	.3	.2	.1
Tennessee	1.0	.7	1.4	1.9
Texas	3.7	2.4	2.8	3.5
Utah	.3	.2	.3	.2
Vermont	.1	.1	.2	.1
Virginia	.9	1.4	.1	.3
Washington	3.4	1.7	3.1	3.0
West Virginia	.4	.4	.4	.5
Wisconsin	1.6	1.8	1.9	1.4
Wyoming	.1	.1	*	.1

[1] Includes loss and loss expenses attributed to claims closed during 1970.

* Less than .1

Source: Medical Malpractice Commission Closed Claims Study, 1970, "Summary Activity of all Reporting Companies."

Reproduced from HEW, Appendix, p. 530.

CHART XII

SURGEONS: THE RELATIVE COST OF CONSTANT LEVEL OF MEDICAL MALPRACTICE COVERAGE FOR THE VARIOUS ISO RATING AREAS, 1960-1972.
(National Average = 100)

Rating Territory	Year 1960	1962	1964	1966	1968	1970	1971	1972
Alabama	73.7	60.5	55.0	47.4	59.2	45.0	109.7	99.5
Alaska	155.5	127.7	115.5	99.6	79.4	76.2	109.7	99.5
Arizona	112.4	92.3	98.1	109.9	176.1	134.0	132.8	138.4
Arkansas	71.0	76.0	68.7	65.8	53.4	81.7	73.4	66.6
Los Angeles	243.7	200.0	192.3	-	-	-	-	-
California	243.7	200.0	227.8	282.3	267.0	255.2	252.3	252.2
Colorado	106.1	87.1	80.6	86.4	121.2	115.7	103.9	122.0
Connecticut	62.9	51.7	58.8	55.9	69.3	77.1	80.0	86.8
Delaware	54.0	44.3	45.2	44.2	66.4	56.9	51.1	46.4
District of Columbia	151.5	124.0	127.5	143.7	105.3	67.0	90.7	82.3
Dade and Broward, Florida	120.5	98.9	90.5	78.0	158.7	151.5	136.1	123.5
Florida	-	-	-	107.1	93.8	90.0	80.8	73.3
Georgia	95.3	93.7	84.5	72.8	73.6	60.6	75.9	77.8
Hawaii	81.8	67.2	49.6	108.0	106.8	66.1	118.7	107.8
Idaho	103.4	84.9	74.7	70.9	54.8	52.3	66.0	77.8
Illinois	103.4	84.9	76.3	79.4	56.3	65.2	88.2	80.1
Indiana	81.8	74.5	82.3	81.3	57.7	56.9	61.0	55.4
Iowa	112.4	79.7	80.6	84.6	89.5	56.9	56.1	65.9
Kansas	64.7	69.4	76.8	78.0	62.1	52.3	80.0	72.6
Kentucky	96.2	79.0	74.7	64.4	59.2	66.1	59.4	53.9
Louisiana	84.5	79.7	72.5	62.5	77.9	92.7	83.3	75.6
Maine	106.1	87.1	86.1	74.2	52.0	40.4	36.3	44.2
Maryland	106.1	74.5	68.7	59.2	520	51.4	46.2	41.9
Massachusetts	90.8	74.5	82.3	96.3	69.3	44.1	39.6	35.9
Michigan	97.1	104.8	95.9	99.6	85.1	140.5	126.2	134.0
Minnesota	116.9	96.0	86.1	74.2	67.8	70.7	63.5	101.1
Mississippi	120.5	79.7	61.0	52.6	36.1	36.7	33.0	52.4
Missouri	92.6	83.4	68.7	67.6	56.3	58.8	52.8	64.4
Montana	112.4	92.3	90.5	78.0	66.4	100.1	103.1	93.5
Nebraska	54.0	44.3	43.0	48.9	34.6	46.8	73.4	66.6
Nevada	155.5	127.7	141.1	162.5	116.9	134.0	120.4	163.9
New Hampshire	60.2	63.5	70.3	60.6	40.4	23.0	20.6	18.7
Bergen, New Jersey	94.4	106.3	152.6	172.4	150.1	119.3	107.2	97.3
New Jersey	54.8	62.0	89.9	101.5	122.7	119.3	107.2	97.3
New Mexico	129.5	106.3	98.1	109.9	93.8	95.5	128.6	128.7
New York City	139.4	167.2	161.3	139.1	173.2	206.6	234.8	213.1
New York	89.9	110.7	117.7	101.5	101.0	101.0	90.7	104.0
North Carolina	61.1	50.2	46.9	40.4	37.5	32.1	28.9	34.4
North Dakota	98.9	81.2	72.5	72.8	52.0	36.7	33.0	44.9
Ohio	90.8	81.2	74.7	70.9	56.3	93.6	96.5	101.0
Oklahoma	116.9	120.3	107.9	93.0	86.6	90.9	81.6	74.1
Oregon	181.6	149.1	139.5	155.5	134.2	72.5	81.6	74.1
Pennsylvania	60.2	63.5	68.7	65.8	70.7	63.3	56.9	51.6
Puerto Rico	84.5	69.4	64.8	61.1	54.8	63.3	56.9	51.6
Rhode Island	55.7	54.6	51.2	57.3	49.1	34.0	30.5	27.7
South Carolina	75.5	53.1	49.0	42.3	33.1	28.5	25.6	23.2
South Dakota	98.9	81.2	72.5	72.8	50.5	33.6	50.3	45.7
Tennessee	120.5	124.0	111.7	96.3	75.0	52.0	47.0	42.7
Texas	64.7	69.4	62.7	64.4	57.7	55.1	49.5	44.9
Utah	101.5	67.2	61.0	65.8	60.6	84.0	85.3	77.4
Vermont	54.0	44.3	41.4	39.0	27.4	34.9	31.3	28.4
Virginia	116.9	76.8	64.8	55.9	49.1	59.6	58.6	53.1
Washington	88.1	86.4	78.5	67.6	93.8	90.0	101.4	92.1
West Virginia	58.4	48.0	45.2	47.4	36.1	52.3	82.5	74.8
Wisconsin	144.8	106.3	86.1	74.2	62.1	59.7	66.8	60.6
Wyoming	55.7	45.8	45.2	42.3	33.2	36.7	33.0	29.9
U.S.Average (in dollars)	$229.1	$279.1	$378.1	$438.5	$571.0	$1880.9	$2094.0	$2307.4

Source: HEW, Appendix, p. 540

CHART XIII

STATE BY STATE COMPARISON OF EXISTING ISO RATES FOR HOSPITALS MALPRACTICE COVERAGE AS OF OCTOBER 1, 1975

State	Rates 25/75	100/300
Alabama	$ 97	$ 157
Arizona	186	301
Arkansas	86	139
California	830	1,345
Colorado	—	—
Connecticut	107	173
Delaware	132	183
Florida	535	867
Georgia	149	241
Idaho	110	178
Illinois	—	—
Indiana	121	196
Iowa	118	164
Kansas	75	104
Kentucky	163	264
Louisiana	188	261
Maine	83	115
Maryland	72	117
Massachusetts	131	182
Michigan	334	541
Minnesota	147	238
Mississippi	83	134
Missouri	109	177
Montana	345	559
Nebraska	109	177
Nevada	94	134
New Hampshire	90	125
New Jersey	54	72
New Mexico	147	238
New York	256	415
North Carolina	27	33
North Dakota	83	134
Ohio	220	356
Oklahoma	111	154
Oregon	203	329
Pennsylvania	100	139
Rhode Island	20	28
South Carolina	61	85
South Dakota	62	101
Tennessee	110	153
Texas	—	—
Utah	142	230
Vermont	39	55
Virginia	112	181
Washington	196	318
West Virginia	51	71
Wisconsin	58	94
Wyoming	82	133
Hawaii	—	—
Alaska	144	233
MONTANA'S NATIONAL RATING	3rd	3rd

Source: Insurance Services Office.

Reproduced from Utah's Office of Legislative Research, Medical Malpractice Insurance Problems (1976), p. 9.

CHART XIV

RELATIVE PER BED RATES FOR HOSPITAL PROFESSIONAL LIABILITY INSURANCE BY RATING TERRITORY, 1960, 1966, 1972
(Connecticut=100)

Rating Territory	Year 1960	1962	1964	1966	1968	1970	1971	1972
Alabama	62.4	59.3	59.2	51.3	36.8	45.1	25.0	(same
Alaska	62.4	59.3	59.2	51.3	36.8	27.1	25.0	as
Arizona	118.5	112.7	112.5	128.2	122.7	81.2	75.1	1971)
Arkansas	46.8	44.5	44.4	38.5	36.8	45.1	41.7	
Los Angeles	218.2	207.7	207.3	–	–	–	–	
California	218.2	207.7	207.3	256.4	245.3	270.8	263.8	
Colorado	93.5	89.0	88.8	64.1	61.3	63.2	75.1	
Connecticut	93.5	89.0	106.6	92.3	88.3	65.0	90.2	
Delaware	46.8	44.5	44.4	76.9	73.6	81.2	75.1	
District of Columbia	171.5	163.2	162.9	141.0	134.9	90.3	83.5	
Dade and Broward, Florida	–	56.4	–	64.1	61.3	72.2	66.8	
Florida	59.0	–	74.0	64.1	61.3	72.2	66.8	
Georgia	96.6	92.0	91.8	115.4	110.4	72.2	66.8	
Hawaii	62.4	59.3	109.6	94.9	90.8	63.2	58.4	
Idaho	49.9	47.5	47.4	41.0	39.3	45.1	41.7	
Illinois	87.3	83.1	82.9	102.6	98.1	31.2	75.1	
Indiana	49.9	47.5	47.4	41.0	39.3	45.1	66.8	
Iowa	96.6	74.2	74.0	102.6	98.1	108.3	100.2	
Kansas	59.2	74.2	74.0	102.6	98.1	81.2	75.1	
Kentucky	46.8	44.5	44.4	38.5	36.8	54.2	50.1	
Louisiana	59.2	74.2	74.0	64.1	73.6	72.2	66.8	
Maine	77.9	74.2	74.0	64.1	61.3	45.1	41.7	
Maryland	68.6	65.3	65.1	56.4	73.6	122.3	113.5	
Massachusetts	137.2	118.7	88.8	92.3	88.3	77.6	71.8	
Michigan	84.2	89.0	88.8	102.6	98.1	54.2	50.1	
Minnesota	62.4	59.3	59.2	51.3	61.3	45.1	50.1	
Mississippi	46.8	44.5	44.4	38.5	36.8	36.1	58.4	
Missouri	93.5	89.0	88.8	102.6	98.1	72.2	66.8	
Montana	77.9	74.2	74.0	64.1	61.3	45.1	41.7	
Nebraska	49.9	47.5	47.4	41.0	39.3	45.1	58.4	
Nevada	46.8	44.5	44.4	38.5	36.8	54.2	50.1	
New Hampshire	68.6	80.1	80.0	64.1	61.3	45.1	41.7	
Bergen, New Jersey	121.6	115.7	115.5	100.0	95.7	70.4	85.9	
New Jersey	121.6	115.7	115.5	100.0	95.7	70.4	85.9	
New Mexico	74.8	71.2	71.1	61.5	58.9	54.2	66.8	
New York City	99.8	142.4	142.1	123.1	117.8	130.6	120.2	
New York	99.8	94.9	94.8	82.0	117.8	130.0	120.2	
North Carolina	46.8	44.5	44.4	38.5	36.8	27.1	25.0	
North Dakota	46.8	44.5	44.4	38.5	36.8	27.1	25.0	
Ohio	146.5	154.3	154.0	133.3	127.6	144.4	133.6	
Oklahoma	77.9	74.2	88.8	64.1	61.3	54.2	80.1	
Oregon	90.4	86.0	85.4	64.1	61.3	63.2	58.4	
Pennsylvania	65.5	62.3	62.2	53.8	63.8	72.2	100.2	
Puerto Rico	74.8	71.2	71.1	51.3	49.1	36.1	50.1	
Rhode Island	106.0	100.9	100.7	87.2	83.4	61.4	56.8	
South Carolina	68.6	59.3	59.2	38.5	36.8	51.2	50.1	
South Dakota	46.8	44.5	44.4	38.5	36 8	27.1	25.0	
Tennessee	53.0	50.4	50.4	64.1	61.3	45.1	41.7	
Texas	53.0	50.4	50.4	38.5	36.8	54 2	50.1	
Utah	56.1	53.4	53.3	46 2	44.2	45.1	41.7	
Vermont	77.9	74.2	88.8	64.1	61.3	63.2	58.4	
Virginia	56.1	53.4	53.3	46.2	44.2	32.5	50.1	
Washington	71.7	89.0	38.8	64.1	61.3	90 3	83.5	
West Virginia	46.8	44.5	44.4	38.5	36.8	36.1	33.4	
Wisconsin	59.2	56.4	56.3	48.7	46.6	45 i	46.7	
Wyoming	49.9	47.5	47.4	41.0	39.3	28.9	26.7	
U.S. Average (in dollars)	$66.1	$69.4	$69.6	$80.4	$84.0	$114.i	$123.4	

Source: HEW, Report of the Secretary's Commission on Medical Malpractice, Appendix, p. 543.

CHART XV

DENTISTS: THE RELATIVE COST OF CONSTANT LEVEL OF MEDICAL MALPRACTICE COVERAGE FOR THE VARIOUS ISO RATING AREAS, 1960-1972.
(National Average = 100)

Rating Territory	Year 1960(13.50)	1966(16.00)	1970(25)	1972(29.00)
Alabama	100.0	100.0	76.0	55.2
Alaska	100.0	100.0	76.0	172.4
Arizona	100.0	100.0	76.0	103.5
Arkansas	100.0	100.0	76.0	75.9
California	203.7	218.8	400.0	344.8
Colorado	100.0	100.0	88.0	103.5
Connecticut	100.0	100.0	100.0	100.0
Delaware	100.0	100.0	88.0	75.9
District of Columbia	166.7	187.5	180.0	203.5
Florida	100.0	125.0	160.0	137.9
Georgia	100.0	100.0	76.0	134.5
Hawaii	NA	NA	NA	NA
Idaho	100.0	100.0	83.0	75.9
Illinois	74.1	84.4	76.0	79.3
Indiana	100.0	100.0	88.0	131.0
Iowa	92.6	84.4	72.0	100.0
Kansas	100.0	100.0	70.0	60.4
Kentucky	74.1	62.5	40.0	75.9
Louisiana	96.3	100.0	80.0	110.4
Maine	100.0	100.0	88.0	100.0
Maryland	100.0	100.0	76.0	86.2
Massachusetts	74.1	62.5	76.0	82.8
Michigan —	100.0	100.0	120.0	155.2
Minnesota	100.0	100.0	96.0	75.9
Mississippi	100.0	84.4	54.0	46.6
Missouri	74.1	62.5	86.0	131.0
Montana	100.0	100.0	86.0	151.7
Nebraska	100.0	100.0	88.0	100.0
Nevada	100.0	100.0	88.0	75.9
New Hampshire	100.0	100.0	74.0	63.8
New Jersey	111.1	118.8	76.0	96.6
New Mexico	100.0	100.0	76.0	65.5
New York City	133.3	168.8	116.0	179.3
New York	111.1	103.1	84.0	127.6
North Carolina	100.0	100.0	64.0	55.2
North Dakota	100.0	100.0	88.0	100.0
Ohio	100.0	100.0	96.0	103.5
Oklahoma	100.0	100.0	88.0	86.2
Oregon	74.1	62.5	88.0	106.9
Pennsylvania	74.1	62.5	60.0	51.7
Puerto Rico	100.0	100.0	100.0	86.2
Rhode Island	74.1	62.5	40.0	34.5
South Carolina	74.1	62.5	40.0	34.5
South Dakota	100.0	100.0	76.0	65.5
Tennessee	100.0	100.0	76.0	65.5
Texas	NA	NA	NA	NA
Utah	100.0	100.0	88.0	113.8
Vermont	100.0	100.0	76.0	65.5
Virginia	100.0	84.4	54.0	46.6
Washington	100.0	109.4	180.0	155.2
West Virginia	100.0	84.4	56.0	48.3
Wisconsin	100.0	62.5	40.0	34.5
Wyoming	100.0	100.0	64.0	65.5
U.S. Average in Dollars	$14.6	$17.2	$26.5	$38.7

Source: HEW, Appendix, p. 542.